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

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234 Based on interviews with staff and record review, the facility failed to ensure 1 of 1 resident (Residents #58) who had diagnoses of schizophrenia and anxiety had a Preadmission Screening and Resident Review (PASRR) prior to admission. The findings were: The North Carolina Medicaid Uniform Screening Tool (NC MUST) record for Resident #58 revealed the resident had a Level II PASRR for serious mental illness in place from 4/02/15 through 3/29/22. On 3/30/22 Resident #58 was changed to a Level I PASRR. There was no evidence a PASRR screening was conducted since 3/30/22. Resident #58 was admitted to the facility on [DATE] with diagnoses including schizophrenia and anxiety disorder. Review of Resident #58's quarterly Minimum Data Set (MDS) dated [DATE] revealed he had severe cognitive impairment, no behaviors, had diagnoses of schizophrenia and anxiety disorder, and had not received psychotropic medication in the past 7 days. Review of Resident #58's progress notes revealed a note by the Social Worker dated 6/18/24 indicating Resident #58 was going to be moved to a long-term care hall for continued facility care. In an interview on 7/09/24 at 3:17 PM, the Administrator revealed Resident #58's PASRR dated 3/30/22 was the Level I PASRR received from the hospital prior to the resident's 4/18/24 admission. She explained, when a resident was admitted for short-term rehabilitation, the facility did not submit a new Level I PASRR to the state until they knew if a resident was going to transition to long-term care. The Administrator further explained, a new Level I PASRR was not submitted because the facility did not know if he was going to stay long term. Once that decision was made, a new PASRR request would be submitted. The Administrator said the Social Worker was going to submit a PASRR request on 7/09/24 because a decision had recently been made that he would be staying for long-term care. The Administrator was not aware residents diagnosed with a serious mental illnees required a PASRR evaluation prior to admission. (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/10/24 at 9:05 AM, the Marketing Director said the facility accepted the PASRR that was submitted by the hospital when a resident was admitted . The policy in the facility was to accept a PASRR that was open and active, regardless of how old it was. The facility would not submit a new Level I PASRR at admission and would use the information in the state PASRR system.

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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. 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. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, observations and staff interviews, the facility failed to ensure there was a physician order for the use of supplemental oxygen (Resident #197) and failed to post signage indicating the use of oxygen outside residents' rooms (Resident #197 and Resident #196) for 2 of 3 residents reviewed for oxygen use. Findings included: 1. Resident #197 was admitted to the facility on [DATE] with diagnoses including pneumonia and congestive heart failure. Resident #197's baseline care plan indicated oxygen therapy was required and a goal to not have signs or symptoms of poor oxygen absorption that was dated 7/4/2024. Interventions included observing for and reporting sign and symptoms of respiratory distress to the physician and providing extension tubing or portable oxygen equipment for ambulation as needed. The physician progress note dated 7/4/2024 recorded Resident #197 was receiving 2 liters per minute of oxygen. On 7/8/2024, there was no physician order for the use of oxygen located in Resident #197's medical record. On 7/8/2024 at 10:11 am, Resident #197 was observed lying in bed receiving oxygen at 2 1/2 liters per minute via nasal cannula. There was no oxygen signage observed outside Resident #197's door indicating oxygen was in use. On 7/9/2024 at 1:07 pm in an interview with Nurse Aide (NA) #1, she stated there was not a red (oxygen in use) sign on Resident #197's door indicating oxygen was in use. She stated it was the nurse's responsibility when Resident #197 was admitted to gather and post an oxygen in use sign outside Resident #197's door when gathering the oxygen regulator. She stated she did not know why the oxygen in use sign was not outside on Resident #197's door and said extra oxygen in use signs were stored in the nurse aide supply room. On 7/9/2024 at 1:20 pm in an interview with Nurse #2, she stated Resident #197 was receiving oxygen therapy and should have an oxygen in use sign outside the door, and she could not recall whether Resident #197 had the oxygen in use sign outside the door, She said nurses and nurse aides both had access to the oxygen in use signage and were responsible for ensuring an oxygen in use signage was posted outside Resident #197's door. On 7/9/2024 at 1:56 pm in an interview with Central Supply, she stated Nurse #1 was responsible for placing oxygen signage that communicated no smoking oxygen in use, outside residents' doors when conducting the admission and did not realize Resident #197 did not have an oxygen in use sign outside on the door. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/2024 at 1:14 pm in an interview with Nurse #1, she explained it was the assigned nurse, central supply or herself (Nurse #1) responsibility to place the oxygen in use sign outside Resident #197's door prior or on admission. She stated ensuring oxygen in use signage was outside Resident #197's door was one of her duties, and she had been too busy with other tasks to check that an oxygen in use sign was outside Resident #197's door. On 7/9/2024 at 1:27 pm in an interview with the Administrator, she explained there had not been a constant Lead Nurse, the person who was responsible on admission for placing the oxygen in use signage outside Resident #197's door. She stated Nurse #1 was acting as Lead Nurse and she had not decided who would assume the responsibility for ensuring oxygen signage was outside residents' doors at this time. The admission Minimum Data Set (MDS) assessment with an admission reference date (ARD) of 7/10/2024 was recorded as in progress and was incomplete. In a follow up interview with Nurse #1on 7/11/2024 at 3:45 pm, she stated there should have been an order entered for oxygen in Resident #197's medical record when admitted to the facility. She explained all nurses could enter physician's orders. She said the facility had standing orders for oxygen, and nurses could call the physician for an order for oxygen as needed. She explained the admitting nurse, who was usually her (Nurse #1), was responsible for ensuring Resident #197 had an order for the use of oxygen. She stated she could not recall completing Resident #197's admission assessment, and there was no order for oxygen on Resident # 196's medical record until 7/9/2024 when it was brought to her attention. On 7/12/2024 at 9:07 am in an interview with the Director of Nursing, she stated there should have been an order for the use of oxygen in Resident #197's medical record and an oxygen in use sign outside Resident#197's door. She said Nurse #1 and/or the nurses assigned to Resident #197 should have ensured there was an order on Resident #197's medical record, and a sign for oxygen in use was outside Resident #197's door to communicate no smoking oxygen was in use. 2. Resident #196 was admitted to the facility on [DATE] with diagnoses including pneumonia and chronic obstructive pulmonary disease (COPD). Resident #196's baseline care plan dated 7/2/2024 included a focus for COPD, and interventions included administering oxygen therapy as ordered by the physician. There was a physician order dated 7/5/2024 for Resident #196 to received oxygen at 3 liters per minute continuously via nasal cannula every shift for oxygen supplement. A review of Resident #196's July 2024 Medication Administration Record (MAR) recorded Resident #196 receiving oxygen at 3 liters per minute daily every shift since admission. On 7/8/2024 at 9:58 am, Resident #196 was observed wearing oxygen 3 liters per minute via nasal cannula. There was no signage communicating oxygen was in use no smoking observed outside Resident #196's door. The admission Minimum Data Set (MDS) assessment with an admission reference date (ARD) 7/9/2024 was recorded as in progress and was incomplete. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/2024 at 1:02 pm in an interview with Nurse Aide (NA) #2, she explained nurses assigned to Resident #196 were responsible for placing oxygen in use no smoking signs outside Resident #196's door. She stated the oxygen in use signs were stored in the medication room with the oxygen tanks. She said she didn't know why there was no signage for oxygen in use outside Resident #196's door. On 7/9/2024 at 1:20 pm in an interview with Nurse #2, she stated there should have been an oxygen in use no smoking sign outside Resident #196's door because she was receiving oxygen continuously. She explained she realized that morning Resident #196 did not have an oxygen in use sign outside on the door but Resident #196 was not in her room and she (Nurse#2) forgot to return to Resident #196's room with a no smoking, oxygen in use sign to place outside Resident #196's door. On 7/9/2024 at 1:56 pm in an interview with Central Supply, she stated Nurse #1 was responsible for placing the signage that communicated no smoking oxygen in use, outside residents' doors when conducting the admission and did not realize Resident #196 did not have an oxygen in use sign outside on the door. On 7/9/2024 at 1:14 pm in an interview with Nurse #1, she explained it was the assigned nurse, central supply or herself (Nurse #1) responsibility to place the oxygen in use sign outside Resident #196's door prior or on admission. She stated ensuring oxygen in use signage was outside Resident #196's door was one of her duties, and she had been too busy with other tasks to check that the oxygen in use sign was outside Resident #196's door. On 7/9/2024 at 1:31 pm in an interview with the Director of Nursing, she stated there should have been a no smoking, oxygen in use sign posted outside Resident #196's door. On 7/9/2024 at 1:27 pm in an interview with the Administrator, she explained there had not been a constant Lead Nurse, the person who was responsible on admission for placing the oxygen in use signage outside Resident #196's door. She stated Nurse #1 was acting as Lead Nurse and she had not decided who would assume the responsibility for ensuring oxygen signage was outside residents' doors at this time.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, staff interviews, and interview with Dialysis Center Nurse, the facility failed to maintain ongoing communication with the dialysis treatment center for 1 of 1 resident reviewed for dialysis (Resident #69). The findings included: Resident #69 was admitted to the facility on [DATE] with diagnoses including end stage renal disease. An active physician order dated 6/11/2024 stated Resident #69 received dialysis on Tuesday, Thursday and Saturday at the local dialysis center. The care plan dated 6/12/2024 indicated Resident #69 was scheduled to receive hemodialysis three times per week due to renal disease with risk for complications: infection, fluid imbalances and hemorrhage from dialysis vascular access port and renal failure. Interventions included checking Resident #69 frequently after any bleeding episodes to ensure no further bleeding, observing, documenting and reporting any signs of infection to the access site and assisting Resident #69 with transfers, walking after returning from dialysis treatments. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #69 was cognitively intact and was receiving dialysis. A review of Resident #69's dialysis communication notebook on 6/9/2024 at 3:30 pm revealed 8 out of the 13 dialysis communication forms in the notebook were not completed by the facility staff prior to dialysis treatment for Resident #69 since admission to the facility (6/13/2024, 6/18/2024, 6/27/2024, 6/29/2024, 7/2/2024, 7/4/2024, 7/6/2024 and 7/9/2024.) The 8 dialysis communication forms did not have the following information recorded from the facility: pre-dialysis vital signs, weight, vascular access or information shared with dialysis center. There were blank dialysis communication forms in Resident #69's dialysis communication notebook. On 7/6/2024, the post dialysis information on the communication form from the dialysis center requested a current list of Resident #69's medications to be sent on the next dialysis day (7/9/2024). On 7/9/2024 post Resident #69's dialysis treatment, the dialysis center communicated with the facility to send a list of Resident #69's current medications on a yellow post-it note observed on the outside of Resident #69's dialysis communication notebook. On 7/9/2024 at 3:55 pm in an interview with Nurse Aide (NA) #2, she stated she was responsible for ensuing Resident #69 was dressed, received breakfast and obtain vital signs before leaving for dialysis, and she couldn't recall obtaining pre-dialysis vital signs on Resident #69 on 7/9/2024. NA #2 could not state a reason why Resident #69's vital signs were not obtained. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/2024 at 3:43 pm in an interview with Nurse #2, she stated when she went to give Resident #69's morning medications on 7/9/2024, a local transportation company had arrived and already taken Resident #69 to the dialysis center. She said she had not completed the dialysis communication form, sent a current list of medications for Resident #69's or administered Resident #69's morning medications on 7/9/2024 prior to Resident #69 going to the dialysis center. She stated she thought Resident #69's scheduled dialysis days had changed to Monday, Wednesday and Friday. When Nurse #2 checked the physician order, she stated Resident #69 was scheduled to receive dialysis on Tuesday, Thursday and Saturday. On 7/11/2024 at 11:54 pm in a phone interview with the Dialysis Center Nurse, she stated the nursing staff at the facility were not completing the dialysis communication forms that communicated vital signs and changes in Resident #69 to the dialysis center prior to Resident #69 receiving dialysis treatments. She said the dialysis center had requested twice on 7/6/2024 and 7/9/2024 for the facility to send a list of Resident #69's current medications, and the facility had not sent the medication list to the dialysis center. She stated the dialysis center had not spoken to anyone specifically at the facility about the nursing staff not completing the communication form or the medication list. On 7/9/2024 at 5:40 pm in an interview with the Director of Nursing, she stated the nurse assigned to Resident #69's was responsible for completing the dialysis communication form that included vital signs and any pertinent information prior to Resident #69's leaving the facility for a dialysis treatment, and Resident #69's dialysis pre-dialysis communication form should had been completed on 7/9/2024 and a current list of Resident #69's medications sent as requested.

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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

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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.

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	345519	A. Building B. Wing	07/12/2024

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Liberty Commons Nsg & Rehab Ctr of Johnston Cty	2315 Highway 242 North Benson, NC 27504

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review and staff interviews, the facility failed to implement monitoring for the side effects for a resident receiving antipsychotics (medications used to treat mental disorders) for 1 of 5 residents reviewed for unnecessary medications (Resident #197) The findings included: Resident #197 was admitted to the facility on [DATE] with diagnoses including dementia, depression and anxiety. Resident #197's baseline care plan dated reviewed on 7/4/2024 included the use of antipsychotic medications. Interventions included performing an Abnormal Involuntary Movement Scale (AIMS), a scale that measures the severity of involuntary movements caused by neuroleptic medications (medications known form their ability to attenuate hallucinations and delusions) assessment and monitoring for side effects of antipsychotics. A review of the active physician orders recorded Resident #197 was ordered the following medications: - Lorazepam (an type of antipsychotic used to treat anxiety and sleeping problems) 0.5 milligrams (mg) every four hours as needed for agitation for 14 days on 7/4/2024. - Haloperidol (an antipsychotic medication used to treat mental disorders) 0.5mg every four hours as needed for agitation until 7/16/2024 on 7/4/2024. - Risperidone (a type of antipsychotic medication that [NAME] mental health conditions) 0.5mg once a day for agitation on 7/3/2024. - Quetiapine Fumarate (antipsychotic medication that treats several kinds of mental health conditions) 25 mg 1/5 tablet every evening for agitation on 7/3/2024. A physician progress note dated 7/4/2024 recorded Resident #197's psychological history included anxiety, depression, dementia, agitation, delusions and hallucinations. A pharmacy review of Resident #197's medications was conducted on 7/4/2024. The pharmacy recommendation requested a diagnose for the medications Risperdal, Seroquel and Haldol which had not completed the recommendation process at the facility at this time. A psychoactive medication interventions consent dated 7/6/2024 listed Quetiapine Fumarate, Risperidone and Haloperidol as medications used to treat Resident #197's agitation. There was no AIMS assessment located in Resident #197's medial record. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the July 2024 Medication Administration Record (MAR) reported Resident #197 had received Risperidone 0.5mg daily since 7/4/2024 and Quetiapine Fumarate 25 mg 1/5 tablet every evening since 7/3/2024. There was no documentation that Resident #197 had received a dose of Lorazepam or Haloperidol. Resident #197's July 2024 MAR further reported the monitoring to indicate the number of antipsychotic side effects every shift was discontinued on 7/3/2024. There was no nursing documentation indicating Resident #197 exhibited any psychological behaviors since admission. The admission Minimum Data Set (MDS) assessment dated with an admission reference date (ARD) of 7/10/2024 was recorded in process and was incomplete. In an interview with Nurse #1 on 7/11/2024 at 3:55 pm, she explained when Resident #197 was admitted on [DATE], the order to monitor for antipsychotic medication side effects from a previous admission in May 2024 was still listed on the electronic MAR. She stated she had to discontinue the order to monitor of antipsychotic side effects from the previous admission in May 2024 before she could activate a new batch order that included the monitoring of antipsychotic side effects. She stated she did not reactivate a new batch order for Resident #197 who was receiving antipsychotic medications and could not give an explanation why she did not activate the batch order for antipsychotics for Resident #197 on the electronic MAR. Nurse #1 further stated an AIMS assessment that was usually conducted by the nursing staff had not been completed at this time for Resident #197. She explained usually in morning clinical meetings will catch when AIMS assessment had not been completed but due to Resident #197 admission prior to a holiday and the weekend, the facility had not held a morning clinical meeting to discuss Resident #197's need for an AIMS assessment. In an interview with the Director of Nursing on 7/12/2024 at 9:11 am, she stated due to Resident #197 receiving the antipsychotics, Risperidone and Quetiapine Fumarate daily, the nursing staff should complete an AIMS assessment and monitor for and document on the MAR side effects of the antipsychotics. She explained when antipsychotics were ordered by the physician, there was a batch of orders for nurses to activate that included the monitoring and documentation for antipsychotic medications that was not activated for Resident #197. She stated morning clinical meeting had not been held due to a holiday prior to the weekend to ensure AIMs assessment had been completed since Resident #197's admission on 7/3/2024.