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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nursing & Rehabilitation Center Of	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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review, and interviews with residents and staff, the facility failed to resolve repeat concerns and/or to communicate the facility's efforts to address concerns voiced during organized resident group meetings (Resident Council and Dietary Council) related to call-light response times, housekeeping services, and dietary services during 6 of 6 monthly meetings (May 2025, June 2025, July 2025, August 2025, September 2025, and October 2025).The findings included:Resident Council Meeting Minutes dated 5/28/2025 included concerns related to housekeeping services, ice, water, snacks, call light strings needing to be fixed, and a resident being told that there was no gauze in the facility. The minutes indicated that Dietary had been marked off the agenda and no dietary concerns were included in the Resident Council minutes. The Resident Council Communication Form attached to the 5/28/2025 meeting minutes indicated the concerns about strings on call lights and a lack of gauze in the building were the only issues addressed. There was no documentation showing that dietary concern or housekeeping concerns were addressed or resolved.Resident Council Meeting Minutes dated 6/30/2025 identified concerns related to call-light response times and room cleaning. The Resident Council Communication Form attached to the 6/30/2025 meeting minutes indicated that Administrator spoke with staff and encouraged them to answer call lights promptly and administrator stated several new housekeeping staff had been hired and were orienting. Resident Council Meeting Minutes dated 7/31/2025 showed repeat concerns related to call-light response times and room cleaning noted in June.The Resident Council Communication Form attached to the 7/31/2025 revealed there was no documented evidence of facility response or resolution to the repeat concerns related to call-light response times and room cleaning.Resident Council Meeting Minutes dated 8/27/2025 showed repeat concerns related to call-light response times and room cleaning.The Resident Council Communication Form attached to the 8/27/2025 meeting minutes indicated staff received routine customer service education, management would continue to monitor call lights and the Environmental Services Supervisor was to meet with housekeeping staff.Resident Council Meeting Minutes dated 9/30/2025 again included repeat concerns regarding call-light response times and room cleaning.The Resident Council Communication Form attached to the 9/30/2025 meeting minutes indicated call lights response time being monitored by camera. Resident Council Meeting Minutes dated 10/30/2025 documented resident concerns regarding menu choices, call bell response times and rooms cleaning.The Resident Council Communication Form attached to the 10/30/2025 meeting minutes stated to continue to monitor call lights via camera and a housekeeping meeting was to be held by the Environmental Services Supervisor. On 11/18/2025 at 2:30 PM interviews with Resident #18, Resident #5, Resident #37, Resident #49, Resident #61, Resident #91 and Resident #6 revealed that dietary issues, call light concerns and housekeeping concerns were ongoing and remained unresolved. Residents stated they had been expressing these same concerns for months with no resolution. Residents stated they were no longer able to voice food concerns during Resident Council because a separate Dietary Council had been created. Residents stated that they had many complaints about food and were told by the Activities Director to tell the Dietary Manager, but the residents did not feel as if he (the Dietary Manager) was approachable. The residents indicated that whenever they attempted to bring up food concerns to the Dietary Manager, he would shrug them off or dismiss their concerns. The residents could not recall the date of the last Dietary Council meeting or if the Dietary Manager attended. They stated whenever the Dietary Manager did attend, he sat quietly rolling his eyes to the point they would be hesitant to voice any concerns. The residents reported that the Dietary Manager did not attend any Resident Council meetings but if they brought up a food complaint they would be told by Activities Director to wait and discuss it at Dietary Council meeting. Residents reported they did not receive updates regarding any actions taken or resolutions for concerns voiced during the Resident Council or Dietary Council meetings. An interview conducted with the Activities Director on 11/18/2025 at 4:50 PM revealed she documented Resident Council minutes, took the concerns from the minutes to the Administrator, and the Administrator completed the Resident Council Communication Forms. The Activities Director stated she did not bring resolved or pending issues back to the next Resident Council meetings, she just verbally communicated the resolution to the resident that voiced the complaint. She verified that residents did voice repeat concerns about housekeeping and call light response times at the Resident Council meetings. The Activities Director stated she started Dietary Council meetings in May 2025 so that the Resident Council meetings were not taken over with dietary concerns. She indicated that Dietary Council meetings normally took place a few days before the Resident Council meetings, but she could not

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Ombudsman interviews, the facility failed to send a copy of the notice of transfer to the Long-Term Care (LTC) Ombudsman for 1 of 2 residents transferred to the hospital (Resident #103). The findings included:Resident #103 was admitted on [DATE].A review of a progress note dated 8/23/2025 indicated Resident #103 was transferred to the hospital. Resident #103 did not return to the facility.An interview on 11/19/2025 at 11:20 am with the Social Services Director revealed the social services department notified the Ombudsman via email about discharges/transfers. The Social Services Director could not see in facility records that the Ombudsman was notified of the August discharges or transfers or any transfers regarding Resident #103. An interview with the LTC Ombudsman for facility on 11/19/2025 at 12:00 pm revealed the Ombudsman did not receive notification of any discharges/transfers for August from the facility. The Ombudsman further stated they did not receive any information regarding Resident #103's transfer or discharge.On 11/19/2025 at 2:00 pm an interview with the Administrator revealed her expectation was for staff to make certain that the Ombudsman received discharges/transfers monthly the way the Ombudsman had requested to receive the notices. The Administrator acknowledged the facility did not send the email for August but could show documentation for September and October. The Administrator did not know why the email was not sent to the Ombudsman in August.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code a Minimum Data Set Assessment for prosthetics for 1 of 24 residents reviewed for accuracy of assessments (Resident #12).The findings included:Resident #12 was admitted to the facility on [DATE] with diagnoses which included bilateral below the knee amputations and hemiplegia (paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following cerebral infarction. Review of Resident #12's care plan with a revision date of 6/4/25 revealed a focus for bilateral below the knee amputations and the use of bilateral prosthetic legs. Review of Resident #12's quarterly Minimum Data Assessment (MDS) dated [DATE] revealed he was not coded for limb prothesis. During an interview with the MDS Coordinator on 11/19/25 at 4:42 pm, she stated the MDS should have indicated Resident #12 had bilateral below the knee prosthetics and this had been an error. She verified that the Minimum Data Set Assessment was inaccurate and MDS should have been coded correctly. During an interview with the Administrator on 8/7/25 at 2:00 pm, she stated the MDS assessments should have been coded accurately for Resident #12's bilateral below the knee prosthetics.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to include the use of supplemental oxygen on the baseline care plan for 1 of 2 residents reviewed for baseline care plans (Resident #54).Findings included:A review of Resident #54's hospital's Discharge summary dated [DATE] did not indicate the use of oxygen while Resident #54 was in the hospital.Resident #54 was admitted to the facility on [DATE]. Diagnoses included atherosclerotic heart disease and chronic idiopathic (unknown cause) venous hypertension with ulcers to both lower legs.Nursing documentation dated 11/10/2025 at 8:58pm by Nurse #2 recorded Resident #54 was receiving oxygen by nasal cannula oxygen.Resident # 54's baseline care plan dated 11/12/2025 included focus areas for pressure ulcers and non-pressure ulcer wound care, use of pain medications and anti-anxiety medications and the use of a peripheral inserted central catheter (PICC) for administration of intravenous antibiotics. The use of oxygen was not included as a focus area on Resident #54's baseline care plan.In an interview with MDS (Minimum Data Set) Nurse #1 on 11/20/2025 at 11:08am, she stated the MDS Coordinator would have started Resident #54's baseline care plan on admission. She stated on 11/16/2025, she completed Resident #54's MDS assessment for the use of oxygen and should have updated the baseline care plan for the use of oxygen at that time.In an interview with MDS Coordinator on 11/20/2025 at 11:14am, she explained she was not aware that Resident #54 had been receiving oxygen since admission to the facility. She explained the reason there was no focus area for the use of oxygen on Resident #54's baseline care plan was because there was no physician order on Resident #54's EMR when admitted to the facility. The MDS Coordinator further stated Resident #54's baseline care plan should have been updated after assessed by MDS Nurse #1 for the use on oxygen on 11/16/2025.In an interview with the Administrator on 11/20/2025 at 12:54pm, she stated Resident #54's admission orders were discussed the following morning in the clinical morning meeting. She explained Resident #54's discharge orders from the hospital did not include an order for oxygen therapy that led the MDS Coordinator not to include a focus for oxygen therapy on Resident #54's baseline care plan. She stated the individualized person-centered baseline care plan should be accurate and updated as needed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to complete quarterly smoking assessments for 1 of 1 resident reviewed for smoking (Resident #23).The findings included: Review of the facility's smoking policy dated 2/2025 revealed a smoking assessment must be completed upon admission, quarterly, and upon changes in the resident's condition. Resident #23 was admitted to the facility on [DATE] with diagnoses which included hypertension, muscle weakness, dementia, and blindness in one eye. Review of Resident #23's annual Minimum Data Set (MDS) dated [DATE] revealed the resident was coded for tobacco use. Review of Resident #23's quarterly MDS dated [DATE] revealed the resident was moderately cognitively impaired and needed assistance for most activities of daily living (ADL). The MDS indicated Resident #23's mobility device was a wheelchair. Resident #23 was coded for tobacco use. Review of Resident #23's smoking assessments revealed smoking assessments were completed on 2/28/25 and 11/13/25. Review of Resident #23's care plan dated 11/17/25 revealed the resident was a supervised smoker. The goal was for Resident #23's smoking related injuries to be minimized with intervention through next review. Interventions included smoking assessment to be completed quarterly per facility policy. Resident #23 was observed smoking on 11/19/25 at 9:18 am. Resident #23 was supervised while smoking and no concerns or issues were noted. An interview was conducted with Team Leader #1, who was a nurse, on 11/18/25 at 2:30 pm and she revealed smoking assessments were expected to be completed quarterly by the Team Leaders and/or the Assistant Director of Nursing (ADON). Team Leader #1 indicated nurses were notified by the computer what assessments were pending and needed to be completed during their shift, and they were expected to do so. Team Leader #1 indicated she was not aware Resident #23's smoking assessments had not been completed quarterly. During an interview with the Assistant Director of Nursing (ADON) on 11/20/25 at 12:30 pm, she revealed Resident #23 was the only smoker in the facility. The ADON indicated the computer system notified staff when a resident's assessment needed to be completed. The ADON explained that the Team Leaders were responsible for completing the smoking assessments quarterly; however, other members of the management staff could complete the smoking assessments if the Team Leaders were busy. The ADON further indicated she completed Resident # 23's smoking assessment on 11/13/25. The ADON stated she was not aware that Resident #23 had missing smoking assessments. The Administrator was interviewed on 11/20/2025 12:16 pm and indicated her expectations were that the smoking assessments should be completely quarterly as stated in the smoking policy.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff and Physician interviews, the facility failed to perform a weekly dressing change to a resident's peripherally inserted central catheter (PICC), a long, thin tube inserted through a vein in your arm and passed through the larger veins near your heart to deliver medication and/or treatment, as ordered for 1 of 1 resident sampled for receiving antibiotics intravenously (inside the vein) through a PICC line (Resident #54). Findings included:Resident #54 was admitted to the facility on [DATE] and diagnoses included chronic idiopathic (cause unknown) venous hypertension with ulcers to both lower legs. A review of the hospital's Discharge summary dated [DATE] included an order to flush the PICC line with heparin 10 units per milliliter every 12 hours. There were no orders for PICC dressing change. Physician orders dated 11/10/2025 included an order to change PICC line dressing with sterile procedure weekly and as needed, measure the length of the exposed catheter to check for migration every day shift every Friday for line care.An incomplete in process admission Minimum Data Set (MDS) assessment indicated Resident #54 was moderately cognitively impaired, was receiving intravenous antibiotics and had an intravenous access. Resident #54's baseline care plan dated 11/12/2025 included a focus for intravenous medications via PICC with risk for complications such as infection and infiltration. Interventions included performing dressing change to site per protocol and inspecting the site for redness, inflammation, bruising or change in location and reporting to MD if noted. There was no nursing documentation that Resident #54's PICC dressing had been changed since admission.A review of the November 2025 Medication Administration Record (MAR) recorded Nurse #1 documented NA (not applicable) on Friday, 11/14/2025, for changing the PICC dressing. On 11/17/2025 at 12:43pm, Resident #54's transparent PICC dressing was observed dated 11/10/2025. The PICC site was observed with no redness, swelling or drainage underneath the transparent dressing. In an interview with Nurse #1 on 11/18/2025 at 5:54pm, she stated she did not change the PICC dressing as ordered on 11/14/2025 because she knew the PICC dressing was to be changed every 7 days and the 14th was only 4 days from the date on the PICC dressing. She explained she discussed the PICC dressing with someone (unable to recall who) on 11/14/25 and was told to record NA since the dressing was not due to be changed. Nurse #1 stated the team leaders enter admission orders into the electronic medical record (EMR) and she did not recall informing or discussing with the team leaders changing the PICC dressing order to reflect 7 days from 11/10/2025. She explained the November MAR was not prompting a PICC dressing change for 11/17/2025 and she did not work on 11/17/2025 when the PICC dressing should have been changed. On 11/19/2025 at 11:45am, Resident #54's transparent PICC dressing was observed dated 11/10/2025. The site was observed with no swelling, redness or drainage under the transparent dressing. In an interview with Nurse #1 on 11/19/2025 at 11:50 am, she stated she didn't know who was responsible for changing the PICC dressing. She stated she reported to Team Leader #1 on 11/18/2025 the PICC dressing had not been changed 11/14/2025 and the Team Leader reported the wound nurse was to change the PICC dressing. Nurse #1 stated she would add changing the PICC dressing to her list to complete on 11/19/2025 if not changed by the wound nurse, who was responsible for changing the PICC dressing. In an interview with Team Leader #1 on 11/19/2025 at 11:54am, she stated she wasn't aware who entered the PICC dressing to be changed on 11/14/2025 because the policy stated to change PICC dressing every 7 days. In a follow up interview with Team Leader #1 on 11/19/2025 at 12:24 pm, she stated Nurse #1 should have changed the PICC dressing on 11/14/2025 as ordered and clarified that the assigned nurses to Resident #54 were responsible to change the PICC dressing, not the wound nurse.On 11/19/2025 at 3:34pm, Nurse #1, assisted by the Staff Development Coordinator (SDC) Nurse, was observed using enhanced barrier precautions and sterile technique to change Resident #54's PICC dressing. The PICC insertion site was without redness, swelling or drainage. Resident #54 voiced no complaints of tenderness at the PICC site. The PICC catheter was measured at 13 centimeters and the site as cleansed, secured and dressed using a new transparent dressing. In an interview with the Assistant Director of Nursing on 11/20/2025 at 11:24am, she stated she entered the order for Resident #54's PICC dressing on 11/10/25 and chose Fridays as the day to change the PICC dressing weekly starting on 11/14/2025. She explained the MAR was set to trigger Nurse #1 to change the PICC dressing on 11/14/202, and Nurse #1 should have changed the PICC dressing on 11/14/2025. The ADON explained there was nothing wrong with changing a PICC dressing before the 7-day period. On 11/20/2025 at 10:33am in an interview with the Director of

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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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and resident and staff interviews, the facility (a) failed to obtain a physician order for the use of oxygen and (b) failed to place signage outside the resident's door indicating the use of oxygen for 1 of 2 residents reviewed for oxygen use (Resident #54).Findings included:(a) Resident #54 was admitted to the facility on [DATE] and diagnoses included atherosclerotic heart disease. A review of the hospital discharge orders dated 11/10/2025 did not include orders for oxygen therapy for Resident #54. A review of the physician progress notes included no record of Resident#54 receiving oxygen.In an interview with Nurse #1 on 11/18/2025 at 4:50pm, she stated the assigned team leader on 11/10/2025 was responsible for entering the oxygen order. In a follow-up interview with Nurse #1 on 11/20/2025 at 7:50 am, she stated she was the nurse assigned to Resident #54 on 11/10/2025 and was unable to recall receiving report from the hospital that Resident #54 was receiving oxygen or that Resident #54 was wearing oxygen when arriving to the facility. Nursing documentation dated 11/10/2025 at 8:58pm by Nurse #2 recorded Resident #54 was receiving oxygen by nasal cannula oxygen and oxygen saturation was recorded at 91 percent (normal range 95-100%). There was no nursing documentation of the amount of oxygen Resident #54 was receiving. In a phone interview with Nurse #2 on 11/20/2025 at 9:10am, she stated she thought Resident #54's room was already set up for oxygen on 11/10/2025 before she started her shift at 7:00pm and could not recall if oxygen in use signage was placed outside the door. She explained she usually checked for oxygen therapy orders and didn't know why she did not check for Resident #54. There was further nursing documentation on 11/14/2025 at 11:36pm, 11/5/2025 at 11:58pm and 11/17/2025 at 12:18 am by Nurse #5 that Resident #54 was receiving oxygen via nasal cannula. There was no nursing documentation of the amount of oxygen Resident #54 was receiving. An attempt to interview Nurse #5 was unsuccessful.MDS (Minimum Data Set) Nurse #1 documented on 11/16/2025 that Resident #54 was receiving oxygen via nasal cannula. There was no documentation of the amount of oxygen Resident #54 was receiving.In an interview with MDS Nurse #1 on 11/20/2025 at 11:08am, she stated on 11/16/2025 Resident #54's MDS assessment for the use of oxygen was completed and Resident #54's MDS assessment was coded for the use of oxygen. She explained data for Resident #54's MDS assessment continued to be completed and was currently incomplete. She explained she was not aware there was no order for oxygen therapy in the EMR (Electronic Medical Record). She stated residents receiving oxygen therapy should have an order in the EMR. Nursing documentation on 11/17/2025 at 8:17pm by Nurse #4 documented Resident #54 was receiving oxygen via nasal cannula. There was no nursing documentation of the amount of oxygen Resident #54 was receiving. In a phone interview with Nurse #4 on 11/20/2025 at 8:52am, she stated she thought she had prompted the oxygen orders in the EMR for Resident #54's oxygen therapy when assigned to Resident #54 on 11/17/2025. She explained when there was no order for Resident #54's oxygen therapy, nursing staff should have told the team leader or entered an order. She stated she did not know why there was no order for oxygen in Resident #54's EMR. She stated it was an oversight by herself and the nursing staff. There was no documentation of oxygen use on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) from 11/10/2025 to 11/18/2025. On 11/17/2025 at 12:43pm, Resident #54 was observed receiving oxygen therapy at two liters per minute via nasal cannula.On 11/17/2025 at 12:44pm in an interview with Resident #54, she stated she started using oxygen while in the hospital and had been receiving oxygen since her admission to the facility. In an interview on 11/18/2025 at 5:22pm with Team Leader #2, she stated nursing staff were responsible to obtain an order for oxygen when oxygen was in use and place signage indicating no smoking, oxygen in use outside the door. She explained the central supply personnel would set up the concentrator and place the sign on the door when an oxygen order was included in the discharge orders. She stated the team leaders reviewed the admission orders and entered the orders into the EMR when residents were admitted before 5:00pm and the assigned nurse was responsible after 5:00pm. Team Leader #2 stated she did not know exactly what time Resident#54 arrived at the facility on 11/10/2025 and she did not know why there was no order for oxygen therapy for Resident #54 on the EMR. In an interview with Team Leader #1 on 11/19/2025 at 11:54am, she explained there was no order on Resident #54's chart prior to the evening hours of 11/18/2025 when she showed Nurse #1 how to activate the orders for oxygen therapy for Resident #54 who was receiving oxygen. She stated Resident #54 had been receiving oxygen therapy since admission and should have had an order. Team Leader #1 stated