STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

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LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 000}	INITIAL COMMENTS	{F 000}		

A revisit to the complaint survey of 5/26/2021 was conducted on 6/16/21 through 6/17/2021. The Immediate Jeopardy that began 11/17/2020 was determined to be removed on 6/12/2021. The facility provided a Credible Allegation of Removal and was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit in order to determine if corrective actions implemented by the facility have been able to demonstrate removal of the Immediate Jeopardy.
Based on observation, staff interview, record review, in-service review, the Immediate Jeopardy was determined to be removed on 6/12/21. The facility will remain out of compliance at Scope and Severity of "E" for F-759 as a deficiency that constitute no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy.

The validation of the Credible Allegation of Removal on 6/16/21 through 6/17/2021 beginning 11:00 AM was accomplished through observation, staff interview, record review, and in-service review.

Based on verification of the facility's corrective actions validated by observation, staff interview, record review, and in-service review, the Immediate Jeopardy was removed, and the Scope and Severity was lowered as follows: Regulatory tags F-740 was lowered from a "J" to a "D", Regulatory Tags F-600, F-609, F-656, F-657, F-686, F-726, F-741, F-755, F-760, F-842, and F865 were lowered from a "K" to an "E", and Regulatory tags F-725, F-835, F837, F838, and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/07/2021

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{F 000}	Continued From page 1 F841 were lowered from an "L" to an "F", while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.	{F 000}		
{F 600} SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, facility policy review, and hospital discharge recommendations, the facility failed to ensure residents were protected from abuse as evidenced by: 1) Resident #1 yelling at residents, hitting residents, and pulling the hair of Resident #6, and physical contact with Resident #9. 2) The facility staff failed to follow the no manual lift policy. The facility staff also failed to follow the mechanical lift policy requiring two (2) persons	{F 600}	1. Residents # 1□'s incidents have been thoroughly investigated by the Interdisciplinary Team and recommendations have been stated. Resident #1 was noted with acute behaviors of hitting and pulling Resident #6 hair and was transported to the Oceans Behavioral Health on 4/20/2021 per physician orders. Resident #1 returned to facility on 4/30/21 from behavioral health. On May 4th Resident	7/14/21

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{F 600}	Continued From page 2 assist with transfer which resulted in major injuries for Resident #2 and Resident #14. The facility failed to ensure residents were protected from abuse and neglect for five (5) of 24 residents reviewed for abuse and neglect. The facility's failure to ensure resident's rights to be free from abuse and neglect. The facility's actions placed these and other vulnerable residents in a situation that would likely cause serious harm, injury, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) on 5/20/21 and determined to be effective on 3/17/21 when Resident #1 was admitted to the facility and physical/verbal abuse of other residents occurred. The IJ and Substandard Quality of Care (SQC) existed at CFR§483.12, §483.12(a) §483.12(a)(1) Freedom from Abuse, Neglect, and Exploitation The IJ was not removed prior to the State Agency (SA) exit on 5/26/21 and was considered ongoing. The facility provided a Credible Removal Plan, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interviews and in-service sign-in sheets review. The facility provided evidence the facility had implemented corrective actions listed	{F 600}	#9 was hit and pushed by Resident #1. Resident #1 was sent to behavioral health on 5/4/21. Behavioral health facility notified on 5/7/21 that facility was discharging resident to their services on 5/7/21. Resident #6 was evaluated by Social Services Director (SSD) on 4/20/2021 for any psychosocial needs and was determined that no medical evaluation was warranted. The Psychiatric Nurse Practitioner evaluated Resident #6 on 5/07/21. and received Pastoral Consultation on 5/25/21. Resident #9 was evaluated by SSD on 5/6/21, evaluated by the Psychiatric Nurse Practitioner on 5/7/21, and received Pastoral Consultation on 5/25/21. Resident #2 and #14 □ On 4/27/21 Resident #2 was transferred to hospital for x-ray per MD orders. Daughter notified of incident on 5/4/21. Xray revealed fractured left distal Upper 3rd tibial diaphysis. On 5/21/21 Resident #14 was transferred to hospital for x-ray per MD order following fall from bed. Xray revealed fracture to left hip. Each resident□s care plan was checked to ensure use of Mechanical lift had two person-assist and was included on their care plan on 5/6/21. Care plans were correct with two person- assist. May 7, 2021 The Psychiatric Nurse Practitioner assessed residents for psychosocial concerns in relation to the aggressive behaviors of Resident #1 as well as those residents with documented behaviors. No new orders were given. Administrator and Director of Nursing (DON) reviewed the event and findings of Resident #2 and #14 with the Medical Director on 5/4/21. On	

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{F 600}	Continued From page 3 in the Credible Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for 42 CFR 483.45(f)(2), §483.12, §483.12(a), §483.12(a)(1) has been lowered from the scope and severity of a "K" to the scope and severity of an "E". The facility will remain out of compliance at Scope and Severity of "E" that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: The facility's, "Behavioral Health Services" policy, undated, stated it is the policy of the facility to provide all residents the necessary behavioral health care and services to assist him or her to reach and maintain the highest practicable level of physical, mental, and psychosocial functioning in accordance with the comprehensive assessment and plan of care. This policy stated behavioral health care plans will be reviewed and revised as needed, such as when interventions are not effective or when the resident experiences a change in condition. The facility's, "Freedom from Abuse, Neglect, and/or Exploitation Prevention Plan Education" policy, revised on 11/14/17, noted the resident has the right to be free from abuse, neglect, misappropriations of resident property and exploitation by anyone, including, but not limited	{F 600}	5/4/21 Certified Nurse Aide (CNA) #3 was removed from the schedule and received a written disciplinary for failure to use the mechanical lift as stated in the Care Plan for Resident #2. CNA #3 was terminated on 6/09/21. On 5/21/21 CNA #11 was suspended and later terminated on 5/24/21 due to not using the mechanical lift as stated in the Care Plan for Resident #14. 2. All residents have the potential to be affected by the deficit practice cited. 3. On 5/6/21, 5/8/21, and 5/21/21 the QAPI Committee met and reviewed the policies in relation to Abuse, Neglect and Misappropriate of Property and use of Mechanical lift. All members agreed on training plan. All staff including agency staff will have education done by facility management staff prior to working in the facility and annually. Beginning 5/6/21 the Regional Nurse and Administrator conducted multiple mandatory in-services with all nurses (RN, LPN, CNAs) and facility employees including abuse, neglect, aggressive behaviors. On 5/6/2021 at 3:52 PM an educational in-service on □Freedom from Abuse and Neglect and Reporting Abuse and Neglect was held by Regional Director of Operation (RDO) for Department Heads - Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON/ICC), Maintenance Director, Human Resources/Business Office Manager (HR/BOM), Dietary Manager (DM), Medical Records Director, Social Service Director (SSD), Housekeeping Supervisor, Minimum Data Set	

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{F 600}	Continued From page 4 to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardian, friends, or other individuals. Abuse-The willful inflection of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. a. Physical Abuse-Includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. b. Mental Abuse-Includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. c. Psychosocial Harm-Include but are not limited to extreme embarrassment, ongoing humiliation, degradation as a human being. d. Neglect-Failure of the facility, it is employees or service providers to provide goods and services to a resident necessary to avoid physical harm, mental anguish, or emotional distress. 1. Any employee who witnesses or has cause to suspect abuse/neglect/misappropriation of property/or exploitation of a resident must report it immediately to the Administrator/Director of Nursing of the facility. Record review of the facility's last Dementia training dated January 21 ,2020, revealed the facility had a Virtual Dementia training with the facility staff. A review of Resident #1 Pre-Admission Screening (PAS) dated 3/30/21, revealed Resident #1 has a diagnosis of Alzheimer's Dementia. The PAS also	{F 600}	Coordinator (MDS Coordinator). Mandatory in-services were conducted with all nursing staff (Registered Nurse, Licensed Practical Nurse, Certified Nursing Aide, Therapy staff) by Regional Consultant and/or Staff Educator concerning a case study of residents involved and policy on use of Mechanical Lift. The ADON/ICC and Nurse Consultant reviewed the current policy on Mechanical Lift for any needed revisions on 5/23/21. No recommendation made. Beginning 5/28/21 the Rehab Director checked off all nursing staff including Certified Nursing Aides with a competency checklist based on return demonstration or verbal demonstration on use of Mechanical lift. The Psychiatric Nurse Practitioner will continue to monitor the residents listed above for potential psychosocial concerns in relation to Resident #1, residents with documented behaviors and those residents receiving psychoactive medications. Psychiatric Nurse Practitioner will monitor all residents bi-monthly. This is an ongoing process. 4. The Director of Social Services for the management company, facility Social Services or Life Connections Coordinator will review progress notes for new behaviors daily times three months. Three residents will be selected to ensure appropriate interventions and updated care plans weekly times four weeks beginning 6/14/21 and monthly times three months beginning 7/14/21. The Rehab Director, Assistant Director of	

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{F 600}	Continued From page 5 revealed Resident #1 does not have a diagnosis or history of a major mental illness. The PAS revealed Resident #1 takes, and has a history of taking, psychotropic medication. A review of the facility's Comprehensive Care Plan dated 4/15/21, revealed Resident #1 has impaired cognitive function/dementia or impaired thought process related to Dementia and has difficulty making decisions. Resident #1 also experiences Short- and long-term memory loss. The intervention was to engage the resident in simple, structured activities that avoid overly demanding tasks. Resident #1 also has an Activities of Daily Living (ADL) self-care performance deficit related to aggressive behavior and confusion. Resident #1 has the potential to be aggressive with staff and other residents related to anger, dementia, and poor impulse control. Resident #1's interventions included (1) administering medications (2) analyzing time of day, places, circumstances (3) assessing and anticipating the resident's needs, triggers and what de-escalates behavior. Resident #1 has communication problems related to cognitive communication deficiencies. The facility intervention is to cue, reorient and supervise as needed. Resident #1 has a mood problem related to known physiological condition with manic features. A review of the facility's Physicians' orders dated May 7, 2021, revealed Resident #1 Alprazolam (mg) 0.5 milligrams orally daily for anxiety, Aricept 10 mg orally at bedtime for dementia, Buspirone HCL 10 mg orally twice a day for anxiety, Namenda 5 mg orally twice a day for dementia, Olanzapine 10 mg orally three times a day for psychosis and Seroquel 300 mg orally at bedtime	{F 600}	Nursing, or Minimal Data Set nurse will monitor the use of mechanical lifts weekly times four weeks beginning 7/1/21 and then monthly times three months beginning 8/1/21. Findings will be brought to Quality Assurance Performance Improvement monthly beginning 7/2/21 for review, revision, or resolution of the plan for six months. Quality Assurance and Performance Improvement minutes will be reviewed by the Regional Director of Operations or Regional Nurse Consultant monthly beginning 7/01/21. Independent monitoring by an outside consulting firm which began 6/7/21 is being performed for compliance assistance. The Administrator will report to the Governing Body and the Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

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{F 600}	Continued From page 6	{F 600}		

for psychosis.

A review of the facility's Nurses' Notes dated 4/20/21 at 11:06 AM, revealed Registered Nurse (RN) #2 overheard Resident #6 say "don't touch my hair." The note revealed RN #2 got up from the nurse's station to see what was going on. RN #2 heard Resident #1 say "I'm going to kill your God D**n A**." Resident #1 repeated the statement two more times.

Observation 5/4/21 at 1:14 PM of Resident #1 pacing up and down the facility hallway speaking in a loud tone and cursing with balled fists. Resident #1 was not wearing shoes or a mask. The facility Administrator attempted to redirect the resident and was unsuccessful. Resident #1 approached the State Agency (SA) pushing her in the chest with his pointer finger. The resident was redirected by facility staff.

On 05/5/2021 at 2:00 PM, in an interview with Resident #6, revealed she is afraid of Resident #1. Resident #6 said Resident #1 hit her and pulled her hair. Resident #6 said Resident #1 continued to yell and scream at her and the other residents. Resident #6 also said if Resident #1 comes up to her again she is going to punch him before he can get to her because she is afraid of him.

During an interview on 05/5/21 at 1:15 pm, with the Director of Nurses (DON) revealed the DON did not talk to resident #6 about Resident #1 hitting her. The DON said she was not part of the admission process when Resident #1 was admitted to the facility. The DON said she told the Administrator that this facility cannot meet the needs of the resident. The DON said Resident #1

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{F 600}	Continued From page 7	{F 600}		

is a danger to himself and others. The DON said the staff told her Resident #1 pulled Resident #6's hair and verbally threatened her. The Doctor wrote orders to send him to a local Behavioral Unit.

A review of the local Behavioral Health notes dated 4/20/21, revealed Resident #1 was admitted 4/20/21 due to aggressive behaviors. Resident #1 presented with psychosis, hallucinations, and aggressive behaviors toward other Residents at the nursing home. Resident #1 continues to pace in the hallways at the nursing home. Resident continued to present with aggression/threatening behavior, medication was given to stabilize him.

A Review of the local Behavioral Health Discharge Summary dated 4/29/21, revealed Resident #1 was discharged with a new prescription to give Seroquel 25 mg by mouth (po) twice a day for psychosis. The order also states to continue Buspirone 10 mg po twice a day for mood disorder, Zyprexa 10 mg every eight hours as needed for psychosis, Seroquel 300 mg po at bedtime for psychosis, Depakote 250 mg po twice a day for seizures and Alprazolam 0.5 mg for anxiety.

A review of the facility's physician's orders revealed Seroquel 25 mg orally twice a day was discontinued on 5/1/21 by the facility Medical Doctor (MD).

Interview with the facility's Medical Doctor on 5/20/21 at 12:30 PM, revealed she discontinued the Seroquel 25 mg orally twice a day because of the black box warning.

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{F 600}	Continued From page 8	{F 600}		

On 05/5/21 at 10:00 AM, interview with the Social Services Director (SSD) states Resident #1's behavior was discussed in a meeting with the Administrator, DON, Assistant Director of Nursing (ADON) and Admissions Director. The SSD said the facility cannot meet Resident #1's needs. The SSD said this resident has too many behaviors and cannot be redirected. The SSD also said she suggested to send Resident #1 to the behavior unit prior to him hitting Resident #6. The SSD confirmed Resident #1's PAS is not correct.

On 5/5/22 at 10:15 AM, with RN #3 said she was sitting at the nurse station on the Alzheimer's Unit (AD) and heard Resident #6 say "do not touch my hair again". The nurse said she did not see Resident #1 hit Resident #6. The nurse said by the time she got down the hall Resident #1 was yelling and threatening Resident #6. Resident #1 said I am going to kill you, "B***h." The nurse said she separated the residents. RN #3 said she has asked the DON and the Administrator several times to send Resident #1 out. The nurse said Resident #1 is dangerous and she is afraid he is going to hurt one of the residents or the staff. RN #3 said Resident #1 is hard to redirect.

On 5/5/21/21 at 10:30AM, in an interview with RN #4, she said she works on the AD unit from 7PM-7AM. RN #4 said Resident #1 was hard to redirect. RN #4 also said Resident #1 curses and yells at the residents constantly. RN #4 said she told the MD that she was concerned Resident #1 might hurt one of the vulnerable residents on the unit. RN #4 said the other residents are scared to death of him.

On 5/5/21 at 10:45 AM, in an interview with The Activity Coordinator (AC) for the AD unit said she

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{F 600}	Continued From page 9	{F 600}		

was responsible for doing Dementia training with the staff. The AC said the staff was trained on hire and annually. The AC said the staff has not been trained in over a year since the pandemic began. The facility has hired several new staff that has not been trained on Dementia care. The AC said when Resident #1 was on the AD unit she had to do one on one activities with him because his attention span was short. The AC coordinator said he was hard to redirect. He would yell and scream at the other residents.

On 5/5/21 at 11:15AM, in an interview with The Business Office/Admissions Manager (BOM) said she is responsible for accepting referrals to the facility. The BOM said she does not have any assessment training. The BOM said she has worked in a nursing home for several years. The BOM said the Administrator sent her to a local nursing home to look at Resident #1, to determine if this facility could meet the needs of the resident. The BOM said the resident was quiet and was not acting out. The DON of that nursing facility said Resident #1 needs to be on a locked unit because he likes to wander and their facility does not have a locked unit.

On 5/5/21 at 11:30 AM, in an Interview with CNA #7 states he works the 7-3 shift. CNA #7 said Resident #1 is hard to redirect. CNA #7 said the resident fights the staff when they attempt to provide care. CNA #7 said the resident continues to curse at the staff and residents. CNA #7 said Resident #1 is impulsive and he walks up to the other residents' face and shake his fist at them. Resident #1 pushes other residents in the facility. CNA #7 said all the residents are afraid of Resident #1.

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{F 600}	Continued From page 10	{F 600}		

On 5/5/21 at 12:00 PM, in an Interview with CNA # 5, said she works the 3-11 shift. CNA #5 said she has not had any in-services on Dementia care since she has been working at the facility. CNA #5 said she tries to avoid Resident #1.

On 5/5/21 at 1:00 PM, in an interview with CNA #6, said she works the 7-3 shift. CNA #6 said she has not had any Dementia Care training.

On 5/5/21 at 1:15 PM, in an interview with the DON, she confirmed the facility has not completed Dementia training since the COVID-19 pandemic. The staff has not had any psychiatric (psych) training. The DON said she was not involved in the admission process. The Corporate office, and the Administrator decides which residents are admitted to the facility. The DON said she did not approve Resident #1's admission. The DON said after the resident was admitted she told the Administrator Resident #1 is difficult to redirect and the facility cannot meet his needs. The DON said Resident #1 has a lot of psychiatric problems. The DON said the staff and the residents are afraid of this resident. She was told they will have to keep the resident and find a way to meet his needs.
On 5/5/21 at 1:30 PM, in an interview with the PNP said she has not been in the facility since March 2020. The PNP said the facility refused to allow her to come in the facility due to Covid-19. The facility called her and asked her to come back to the facility on 05/5/21. The PNP said she assessed and monitored the residents on the AD and the residents that have behaviors. The PNP said she monitors the residents' medications. The PNP said she will be visiting the residents twice a week. The PNP said she will review all Residents that are on psychotropic medications at that time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 600}	Continued From page 11	{F 600}		

On 5/11/21 at 4:35 PM, in an interview with License Practical Nurse (LPN) #14, revealed she worked the AD unit with Resident #1. LPN #4 said Resident #1 cursed the staff and other residents all the time. LPN #14 said Resident #1 continued to call them "b*****s and M****r F*****s" the whole shift. LPN #14 also said Resident #1 is hard to redirect and is impulsive. He runs up to the other resident's faces and draws his fist, yells, and curses at them. LPN #14 confirmed she has not had any behavior or dementia training. LPN #14 said she did not know what to do for Resident #1. LPN #14 said she reported to the DON and the Administrator that the staff did not know what to do to take care of Resident #1 and that he was a danger to himself and the other residents. LPN #14 said she was told to call the doctor and report his behavior. LPN #14 said she was calling the doctor every hour and the doctor finally said do not call her again, call the Administrator because he refuses to send the resident to a behavioral health unit. LPN #14 said the Administrator said he could not send the resident out because his census was low, and he had to keep every resident he could in the building. LPN #14 said she told the Administrator that it is not right that the facility will not get this man some help and causes the other residents to be fearful in their home. LPN #14 said this is the most horrible place, "I've ever worked."

Record review of the Admission Record revealed the facility admitted Resident #1 on 3/17/2021, with the diagnoses that included Dementia with Behavioral disturbance, Epilepsy, Mood disorder and Psychosis. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/26/21, revealed Resident #1 had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 600}	Continued From page 12	{F 600}		

Brief Interview for Mental Status (BIMS) of 00 that indicated Resident #1 is cognitively impaired.

Record review of the Admission Record revealed Resident # 6 was admitted to the facility on 7/31/2017 with diagnoses that included Dementia with Behavioral disturbance, Atrial Fibrillation, Pressure Ulcer, and Anxiety.

Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/26/21, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) of 13 that indicated Resident #6 is cognitively intact.

A review of the facility's Progress Notes dated 5/4/21 at 1:03 PM revealed Resident #1 rushed up to Resident #9's chest. Resident #1 tried to push his chest into Resident #9's chest. Resident #9 raised his hands up to keep him off him. Resident #1 was in and out of other resident's rooms cursing and hollering and taking items off the nurse's station. Resident #1 was sent out to the local behavior unit on 05/4/21.

On 05/6/2021 at 11:00 AM, in an interview with Resident #9 said Resident #1 ran up to him and rammed his chest into his chest. Resident #9 said Resident #1 also hit him. Resident #9 said if Resident #1 comes at him again he is going to knock him out because that man is "crazy." Resident #9 said he told the staff Resident #1 needs to go to a psychiatric hospital because he is going to hurt somebody. Resident #9 said Resident #1 fights the staff all the time and yells and scream at the residents and everybody fears him. "I'm going to hit him before he hit me."

Record review of the Admission Record revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 600}	Continued From page 13	{F 600}		

Resident #9 was admitted to the facility on 1/1/2015 with diagnoses that included Insomnia, Hypertension and Anxiety Disorder.

Resident # 9's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/18/21, revealed Resident #9 had a Brief interview for Mental Status (BIMS) of 15 that indicated Resident #9 is cognitively intact.

On 05/5/2021 at 2:30 PM, in an interview with Resident #22 said Resident #1 paces up and down the hall screaming and cursing at the staff. Resident #22 said the staff cannot manage Resident #1. Resident #22 said she stays in her room because she does not want Resident #1 running up to her and hitting her. Resident #22 said she's afraid Resident #1 will come in room because her door does not lock.

Record review of the Admission Record revealed Resident #22 was admitted to the facility on 2/11/2021with diagnoses that included Diabetes Mellitus, Hypertension and Cerebral Infarction due to Occlusion or Stenosis of right Middle Cerebral Artery.

Resident #22's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/23/21, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) of 12 that indicated Resident #22 is cognitively intact.

On 05/5/2021 at 3:00 PM, in an interview with Unsampled Resident C said she is afraid of Resident #1. Unsampled Resident C said Resident #1 pushed her and almost caused her to fall. Unsampled Resident C also said she did not like going in the day room on the AD unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 600}	Continued From page 14	{F 600}		

because Resident #1 would yell, scream, and curse at her and the staff. Unsampled Resident C said she was afraid he would hit her with his fist because he would ball it up at her and the staff.

Record review of the Admission Record revealed Unsampled Resident C was admitted to the facility on 11/12/2019 with the diagnoses that included Dementia with behavioral Disturbance, Diabetes Mellitus, and Anxiety and Depression.

Unsampled Resident C's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/13/21 revealed Unsampled Resident C had a Brief Interview of Mental Status (BIMS) of 9 that indicated Resident #9 is mildly cognitively impaired.

5/6/2021 at 3:00PM, in an interview with Resident #1's brother he said Resident #1 got in trouble all his life. The brother said they lived together for the last 10 years. Resident #1's brother said Resident #1's behavior continued to get worse. Resident #1 would fight him. He could not handle him. Resident #1's brother said Resident #1 urinated and had a bowel movement on the floor. The brother also said Resident #1 cut him with a knife like a dog. The brother said he could not do anything with him. He placed him in the local nursing home because he could not handle him.

Record review of the facility's "Mechanical Lifts" policy, dated April 18, 2008, revealed, "Policy: "In order to facilitate a safe lifting environment for staff and residents, mechanical lifts are to be utilized for lifting and transferring residents whenever possible. The mechanical lift program will include the following components:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 600}	Continued From page 15 *Resident assessment * Staff training for safety and operation of mechanical lifting devices ... Resident Assessment Residents will be assessed upon admission, quarterly, and with any significant change in condition for lifting and transferring needs and to determine the appropriate method and equipment needed to lift/transfer the resident. This assessment is to be completed by the Registered Nurse or Licensed Physical Therapist. This assessment will identify the type of equipment needed, sling type and size, and number of staff needed to complete the lift or transfer. The assessment will become part of the resident's medical record. The lifting/transferring needs and type of equipment needed will be added to the resident's plan of care and this information made available to unlicensed personnel ... Staff Training Any staff member responsible for lifting and/or transferring residents will receive training on the operation of mechanical devices, application of slings, and safety measures based on the equipment manufactures recommendations. The training must be completed, and competency demonstrated prior to lifting and/or transferring residents..." The manufacturer's, "User Instruction Manual", for the Hoyer HPL700, revealed "2. Safety Precautions ...WARNING DO NOT lift a patient unless you are trained and competent to do so ...6. Operating Instructions ...CAUTION Have someone assist you when attempting to transfer a	{F 600}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 600}	Continued From page 16	{F 600}		

patient."

The User Manual for the Stand-Up Patient Lift, RPS350-1-I from the manufacture revealed staff should observe a trained team of experts perform the lifting procedures and then perform the entire lift procedure several times with proper supervision and a capable individual acting as a patient. The stand-up lift may be operated by one healthcare professional for all lifting preparations, transferring from and transferring to procedures with a cooperative, partial weight-bearing patient. However, since medical conditions vary, Invacare recommends that the healthcare professional evaluate the need for assistance and determine whether more than one assistant is appropriate in each case to safely perform the transfer. The use of the patient lift by one assistant should be based on the evaluation of the healthcare professional for each individual case.

The facility's," Lifting Policy", revealed an acknowledgment "This is to certify that I am not to lift any resident without first obtaining assistance. I hereby agree not to lift any resident by my efforts alone ..."

Resident #2

A record review of the facility's investigation related to Resident #2, revealed a statement from CNA #3 stated, she did not notice any concerns while providing care to Resident #2 on 4/22/21. A review of a statement by CNA #2 revealed she entered Resident #2's room, CNA #3 picked up the resident and placed him in the bed. CNA #2's statement revealed she heard a pop sound and asked CNA #3 was that the resident's leg? CNA #2's statement revealed that CNA #3 thought it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 600}	Continued From page 17	{F 600}		

was the bed that made the popping sound. CNA #2's statement revealed that CNA #3 stated, "Ain't nothing wrong with him", and then walked out of the room.

On 5/6/21 at 3:00 PM, in an interview with the DON revealed the ADON took the statements from all the nurses of what happened the day the resident was injured. The DON said the Administrator finished the investigation and reported it to the SA. The DON said CNA #2 told her that CNA #3 transferred Resident #2 without a lift. Both CNAs were in the room. CNA #2 said she heard a pop and asked CNA #3 if that was the resident's leg. CNA #3 said no that was the bed. CNA #2 stated ok and left the room. The DON stated CNA #2 did not report the incident to the nurse or anybody in the facility until she was asked for a statement. The DON said after she received a statement from CNA #2 the facility determined the fracture was caused by the CNA #3 during transfer. CNA #3 has not been back ever since the incident occurred. The DON stated the Administrator reported the incident to the SA.

On 5/4/2021 at 10:30 AM, in an interview with Resident #2's daughter stated she received a call from a friend letting her know Resident #2's left leg was swollen and twisted. Resident #2's, daughter said she called the facility and was told they do not know what happened to Resident #2's leg. The daughter said she talked to the Medical Nurse Practitioner (MNP) who said this resident has a fracture to his left leg, but she did not know how it happened.

On 5/4/21 at 2:00 PM, in an interview with the MNP, she stated she was informed on 4/25/21 by the nurse that Resident #2 had a bad skin tear to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 600}	Continued From page 18	{F 600}		

the left lower leg. The MNP said the resident's leg was really swollen and she was unable to palpate a pulse in the resident's leg. The MNP said she came back on 4/27/21 to re-evaluate Resident #2's, leg and noted it was flaccid and twisted. The MNP said she called the Medical Director and said the resident needed to go to the hospital for an X-ray to the left leg. The X-ray revealed an acute oblique fracture involving the distal 3rd of the left tibial diaphysis with slight lateral displacement of the distal fracture fragment. The MNP said she talk to the Administrator and the Director of Nursing (DON) saying an investigation needs to be done because Resident #2 could not have received a fracture like this from a bump on the bed. The MNP said she told the Administrator that she would have to report this to the State Agency (SA). The MNP said she called it in to the SA on the hotline as an anonymous complaint.

On 5/4/21 at 2:15 PM, in an interview with Certified Nursing Assistant #1 (CNA), she stated she worked the 11-7 shift on 4/22/21. CNA #1 said she did not receive report from any of the other CNA's. CNA #1 said the resident was in the bed when she came in that night and she checked the resident every two (2) hours to see if he had a bowel movement or had urinated. CNA #1 said she pulled the cover down just to his knee and noted he did not need care. CNA #1 said around 4:30 AM she noted the resident had a large amount of blood on the sheet and said she notified the nurse. CNA#1 said she did not get the resident up that morning. CNA #1 said the resident is care planned to get up with a Hoyer lift with 2 people during transfer.

On 5/4/21 at 2:30 PM, in an interview, Licensed Practical Nurse #1 (LPN) stated CNA #1 came to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 600}	Continued From page 19	{F 600}		

her and reported the resident had dried blood on his sheet around 4:45 AM or 5:00 AM. The nurse said she noted dried blood on the left shin and a thin layer of skin was pulled back on his left leg. The measurements were 6-centimeter (cm)x2.5 cm x0.1cm. The nurse said she cleansed the wound with normal saline, applied topical antibiotic ointment and dry dressing. The nurse said she covered it with a bordered gauze. Tylenol was given for pain. The Physician, DON and Resident Representative (RR) was notified. The nurse said the resident was unable to say what happen to his leg due to confusion.

On 5/4/21 at 2:45 PM, in an interview with the Assistant Director of Nurses (ADON), she stated that on 4/27/21, she received a text from the Physician saying that Resident #2 had a large skin tear on his left leg. The ADON stated that she is off work and will check on it when she comes in. An X-ray was ordered by the doctor because they noted increased swelling and limited range of motion. The results came back, and they saw it was a fracture. The ADON started the investigation and interviews with the staff that was providing care to the resident, on the 3-11 shift. The ADON turned all that information over to Administrator.

On 5/4/21 at 3:00 PM, in an interview with CNA #2 she stated she works the 3-11 shift. CNA #2 stated she works as needed and has worked at this facility for six (6) or seven (7) months. CNA #2 said she went to Resident #2's room on 4/22/21 to see if CNA #3 needed help with transferring the resident back to bed because he is transferred via Hoyer. CNA #2 said when she came in the Resident #2's room, she asked CNA #3 if she wanted her to get the Hoyer lift. CNA #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 600}	Continued From page 20	{F 600}		

stated that CNA #3 stated, "No I always transfer him without assistance." CNA #2 stated when CNA #3 transferred the resident, by lifting him in her arms. CNA #2 stated she heard a loud pop. She asked CNA#3 was that his leg? CNA #3 said no that was the bed. CNA #2 said the facility is a no manual lift facility and the resident is care planned for a Hoyer lift with transfers. CNA #2 said the care plan is under the task bar where the CNA's chart the residents' care. CNA #2 stated she was in-serviced in February on how to use lifts. The CNA #2 stated she has not been in-serviced on reporting. However, she should have told the nurse, but she was concerned with taking care of her residents.

On 5/4/21 at 3:15 PM, in an interview with CNA #3, stated she works the 3-11 shift. CNA #3 said she used the sit-to stand lift to transfer the resident on 4/22/21. CNA #3 said it depends on how the resident is acting that day determines what is used for transfers. CNA #3 said the resident does not have any problems bearing weight. She transfers him all the time with the sit-to stand lift. CNA #3 confirmed she transferred the resident without assistance. CNA #3 stated she did not know about the care plan. CNA #3 stated she did not know the resident was care planned for a Hoyer lift. CNA #3 also revealed she has not had an in-service on reporting.

On 5/4/21 at 3:30 PM, in an interview with Lead CNA #4 revealed she did an Inservice in February on the lifts. CNA #4 said the CNA's task is in the computer. The Comprehensive Care Plan is in the computer stating how the resident is transferred. This facility is a no manual lift facility. CNA #4 stated the facility requires two (2) people with all lifts. CNA #4 stated it has been over a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 600}	Continued From page 21	{F 600}		

year since the facility has done any training on abuse/neglect and reporting. CNA #4 stated the new staff has not been in-serviced on abuse/neglect and reporting.

On 5/13/21 at 12:32 PM, in an interview with CNA #8 stated she has had to work the Alzheimer's and Dementia unit without another CNA and has had to transfer residents via sit to stand and Hoyer without assistance. The CNA said the nurse cannot assist because she cannot leave the residents with behaviors. The CNA said on one occasion she was in the room with a nurse transferring a resident via Hoyer and one of the behavior residents started acting out and they had to run out in the hall to stop the resident from hitting another resident. The staff must do whatever it takes to transfer the resident.

A record review of Resident #2's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD)dated 3/9/21 revealed a Brief Interview for Mental Status score of 7, indicating severe cognitive impairment.

A record review of the Resident #2's Admission Record revealed he was admitted on 6/19/2020.

A record review of Resident #2's Diagnosis Information revealed Fracture of shaft of left fibula initial encounter for closed fracture, Lack of coordination, Muscle Wasting and Atrophy, Muscle Weakness, and Primary Osteoarthritis.

A record review of the Comprehensive Care Plan revealed, Resident #2 has an Activities of Daily Living self-care performance deficit related to limited mobility, limited range of motion. The intervention stated use total lift to maximize

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 600}	Continued From page 22	{F 600}		

independence with transferring.

A record review of the progress notes dated 4/23/21, by LPN #1, revealed she examined Resident #2's leg and observed dried blood on his left shin with bruising around the area. Documentation revealed LPN #1 cleansed the area with normal saline, patted dry and smoothed out the skin and applied triple antibiotic ointment. She then covered with bordered gauze. Measurements at that time was 6 cm x 2.5cm x 0.1cm. LPN #1 contacted Medical Doctor (MD) and the DON.

A record review of the progress notes dated 4/25/21, by LPN #2, revealed skin tear to left leg, area covered with a bordered gauze and dated 4/24/21. LPN #2 removed dressing and observed two sheer appearing tears. The lower tear measured 4 cm and the upper tear measured 2&3/4-3cm. LPN #2 notified MD.

A record review of the progress notes dated 4/27/21 at 18:00 by LPN #3, revealed an order per MD to send Resident to the local hospital for further evaluation for left lower extremity.

A record review of the progress notes dated 4/27/21 at 21:00 by LPN #3, revealed resident received a splint for fracture of fibula/tibia and a prescription for Clindamycin and Norco for pain.

A record Review of the facility's Hoyer and Total lift in-services dated February 10, 2021 revealed the staff was in-serviced on the proper use of the lifts. The in-services instruct the staff to check the residents plan of care for transfer instructions. There shall always be two people with all lift transfers, never lift a resident by yourself. This is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 600}	Continued From page 23	{F 600}		

a no lift facility.

Record review of the most recent Hoyer and Total lift in-service was dated 2/18/21, revealed CNA #3's signature was on the sign in sheet.

A record review of the local hospital Discharge Summary dated 4/27/21, revealed left tibia and fibula fracture.

A record review of the X-ray report from local hospital dated 4/27/21, revealed acute oblique fracture involving the distal 3rd of the left tibia diaphysis with slight lateral displacement of the distal fracture fragment. The joints are not involved.

Resident #14

The facility had not completed investigation prior to state leaving.

On 5/21/21 at 10:00 AM, in an interview with LPN #4 she stated she was called to the Resident #14's room by CNA #14. LPN #4 stated when she arrived in the room, Resident #14 was on the floor on her left side. LPN #4 stated that CNA #11 did not ask for assistance with transferring Resident #14. LPN #4 stated she did not know that the CNA was going to transfer the resident. LPN #4 stated Resident #14 was transferred back to the bed by CNA #15, #16, LPN #4 and #5 by lifting the resident in their arms. LPN #4 stated she notified the doctor, and Resident #14 was transferred to a local hospital.

On 05/24/2021 at 3:15 PM, in a phone interview with CNA #11 she stated on 5/21/21 at 9:29 PM she used the sit to stand lift with the resident. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

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LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 600}	Continued From page 24	{F 600}		

stated she pushed the lift in front of Resident #14 sitting in the wheelchair. She stated she lifted the resident with the sit to stand lift by herself. She stated she did peri care and placed the resident back in the wheelchair. CNA #11 was unable to explain why she used the lift by herself. She stated she felt like she could get the resident with the lift by herself. She stated she was in-serviced on 5/21/21 regarding using a lift. She stated she lifted the resident back up from the wheelchair to put the resident on the bed and thought the resident was sitting on the bed properly. She then removed the lift sling and the resident moved and began to slide out of the bed. She stated she attempted to catch the resident by the arm and was not able to do it. She stated the resident slid off the bed and landed on her left side. She stated she yelled and a CNA in the hallway came to assist her. She stated CNA #15, #16, LPN #4 and LPN #5 lifted the resident off the floor back to the bed, without the lift. She stated LPN #4 and LPN #5 did an assessment on the resident. She stated the resident complained of left leg pain. She stated that while she was assisting the resident with bed linen, she noticed a skin tears to the left elbow and the left leg She further reported she notified LPN # 4 of the blood on the resident's leg. She stated LPN #4 told her to write a statement and leave the facility.

On 05/24/2021 at 3:40 PM in an interview with Assistant Director of Nursing (ADON), she explained she did not do any investigation on the incident. She stated that all individuals who were involved in the incident wrote statements. She stated the statements were left in her box. She explained the DON was notified and was the one who did the investigation of the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 600}	Continued From page 25	{F 600}		

On 05/25/2021 at 09:00 AM, in an interview LPN #5 she stated she was charting at the nurse's station and heard CNA #11 in the hallway yelling help. She stated CNA #15, #16, LPN #4 and LPN #5 went in the resident room and found resident on the floor, laying on her back. She stated Resident #14 was complaining of left leg pain. She stated Resident #14 stated she did not hit her head. She stated CNA #15, #16, LPN #4 and LPN #5 placed the resident in the bed. LPN #5 stated she assessed the resident for injuries. She stated she observed bruises to the right lower back and left shoulder. She stated the resident's left leg thigh area was red, warm to touch, and swollen. The resident also had a skin tear to the left elbow area. She stated she notified the physician and received orders to send Resident #14 out to the local hospital for evaluation. She stated she notified the family LPN #5 stated she notified the DON and ADON of the incident. The DON informed her she would contact the Administrator.

On 5/25/21 at 09:15AM, in an interview with the Administrator he stated LPN #4 phoned him to inform him that CNA #11 had transferred Resident #14 with a sit and stand lift without assistance and the resident slid out of the bed to the floor. He stated the staff was in-serviced on the 5/21/21 before the incident. He stated the local hospital phoned and stated resident had a fractured left hip. CNA #11 was suspended that night and later terminated on 5/24/21. He stated the incident was reported to the Attorney General office.

A record review of Resident #14's Admission Record revealed she was admitted on 5/20/2015.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 600}	Continued From page 26	{F 600}		

A record review of Resident #14 Comprehensive Care Plan reveals transfer extensive x 2 mechanical HOYER lift with size ex-large sling, dated 2/11/2016 and revised on 1/22/2020.

A record review of Resident #14's Diagnoses Information revealed Hemiplegia and Hemiparesis following Cerebrovascular Disease affecting left non-dominant side, Lack of Coordination, other Muscle Spasms, Muscle Weakness and Muscle Wasting.

A record review of the in-service dated 5/21/21 on Mechanical Lift Safety Use, revealed the CNA #11's signature was on the sign in sheet.

A record review of the local hospital X-ray report dated 4/27/21, revealed moderately displaced intertrochanteric left proximal femur fracture or pelvic fractures in the field of view and moderately displaced intertrochanteric left proximal femur fracture.

A record review of the local hospital admission dated 4/27/21 revealed a diagnosis of a Fracture left trochanteric unspecified, closed.

Removal Plan:
The failure to ensure resident's rights to be free from abuse and neglect. Noncompliance at F600 has the potential to affect ail residents in the Facility.
Residents # I's incidents have been thoroughly investigated by the Interdisciplinary Team and recommendations have been stated. Resident #1 was noted with acute behaviors of hitting and pulling Resident #6 hair and was transported to the Oceans Behavioral Health on 4/20/2021 per physician orders. Resident #1 returned to facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 600}	Continued From page 27	{F 600}		

on 4/30/21 from behavioral health. On May 4th Resident #9 was hit and pushed by Resident #1. Resident #1 was sent to behavioral health on 5/4/21. Behavioral health facility notified on 5/7/21 that facility was discharging resident to their services on 5/7/21.
Resident #6 was evaluated by SSD on 4/20/2021 for any psychosocial needs, evaluated again by the Psychiatric Nurse Practitioner on 5/07/21, and received Pastoral Consultation on 5/25/21.
Resident #9 was evaluated by SSD on 5/6/21, evaluated by the Psychiatric Nurse Practitioner on 5/7/21, and received Pastoral Consultation on 5/25/21.
Beginning 5/6/21 the Regional Nurse and Administrator conducted multiple mandatory in-services with all nurses (RN, LPN, CNAs) and facility employees including abuse, neglect, aggressive behaviors.
On 5/6/2021 at 3:52 PM an educational in-service on 'Freedom from Abuse and Neglect and Reporting Abuse and Neglect was held by Regional Director of Operation (RDO) for Department Heads - Administrator, DON, Assistant Director of Nursing (ADON/ICC), Maintenance Director, Human Resources/Business Office Manager (HR/BOM), Dietary Manager (DM), Medical Records Director, Social Service Director (SSD), Housekeeping Supervisor, Minimum Data Set Coordinator (MDS Coordinator).
Resident #2 and #14 - Use of Mechanical Lift
On 4/27/21 Resident #2 was transferred to hospital for x-ray per MD orders. Daughter notified of incident on 5/4/21. Xray revealed fractured left distal Upper 3rd tibial diaphysis.
On 5/21/21 Resident #14 was transferred to hospital for x-ray per MD order following fail from bed. Xray revealed fracture to left hip.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 600}	Continued From page 28	{F 600}		

Each resident's care plan was checked to ensure use of Mechanical lift had two person-assist and was included on their care plan. Care plans were correct with two person- assist.
Beginning 4/28/21 through 5/4/21 mandatory in-services was conducted with all nursing staff (RN, LPN, CNA, Therapy staff) by Regional Consultant and/or Staff Educator concerning a case study of residents involved and policy on use of Mechanical Lift.
On 4/28/21 the ADON/ICC and Nurse Consultant reviewed the current policy on Mechanical Lift for any needed revisions. No recommendation made.
May 7, 2021 The Psychiatric Nurse Practitioner assessed residents for psychosocial concerns in relation to the aggressive behaviors of Resident #1 as well as those residents with documented behaviors. No new orders were given. The Psychiatric Nurse Practitioner will continue to monitor those residents for potential psychosocial concerns in relation to Resident #1, residents with documented behaviors and those residents receiving psychoactive meds.
Beginning 5/28/21 and completed 6/8/21 the Rehab Director, RN or LPN Staff completed competency checklist based on return demonstration or verbal demonstration on use of Mechanical lift.
Administrator and DON reviewed the event and findings of Resident #2 and #14 with the Medical Director on 5/4/21.
On 5/4/21 CNA #3 was removed from the schedule and received a written disciplinary for failure to use the mechanical lift as stated in the Care Plan for Resident #2. CNA #3 was terminated on 6/09/21.
On 5/21/21 CNA #11 was suspended and later terminated on 5/24/21 due to not using the mechanical lift as stated in the Care Plan for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 600}	Continued From page 29	{F 600}		

Resident #14.
On 5/6/21, 5/8/21, 5/21/21, and 5/24/21 the QAPI Committee met and reviewed the policies in relation to Abuse, Neglect and Misappropriate of Property and use of Mechanical lift. All members agreed on training plan and training will be provided to Agency staff by Liberty management staff if they do not have proof of education.
Validation:
The State Survey Agency (SSA) validated through interviews and review of the facility's progress notes Resident #1's incidents have been thoroughly investigated by the interdisciplinary team and recommendations have been stated. Resident #1 was admitted to a behavioral health facility. On 5/7/21 the resident was discharged from the facility.
The (SA) validated through record review Resident #6 was evaluated by the Social Services Designee (SSD) on 4/20/21 for psychosocial needs, evaluated again by the psychiatric Nurse Practitioner (NP) on 5/7/21, and received pastoral consultation on 5/7/21.
The SA validated through record review Resident #9 was evaluated by SSD on 5/6/21 and psych NP on 5/7/21 and received a pastoral consultation 5/25/21.
The SA validated through interviews and review of facility in-service sign in sheets, the Regional Nurse and Administrator conducted multiple mandatory in-services on 5/6/21 with all nurses (RN, LPN, CNA's) and facility employees including Abuse, neglect, aggressive behaviors.
The SA validated through interviews and review of in-service sign in sheets, on 5/6/21 at 3:52 PM an educational in-service on "Freedom from Abuse and Neglect and Reporting Abuse and Neglect" was held by the regional Director of Operations for Department Heads.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 600}	Continued From page 30	{F 600}		

The SA validated through interviews and record reviews, Resident #2 was transferred to the hospital for an x-ray per MD orders, the family was notified of the incident, and the resident was diagnosed with a fractured left distal Upper 3rd tibial diaphysis.
The SA validated through interviews and record reviews, Resident #14 was transferred to the hospital for an x-ray and was diagnosed with a fracture to the left hip.

The SA validated through review of residents Comprehensive Care Plans and staff interviews that each resident's care plan was checked for accuracy related to a two person assist when using the mechanical lift. The care plans were corrected to include a two person assist.
The SA validated through review of in-service sign in sheets mandatory in-services were conducted with all nursing staff (RN, LPN, CNA, Therapy Staff) from 4/28/21 through 5/4/21 by the reginal consultant and/or staff educator concerning a case study of residents involved and policy on use of mechanical lift.
The SA validated through interviews and review of assessments, the Psychiatric Nurse Practitioner (NP) assessed residents on 5/7/21 for psychosocial concerns in relation to aggressive behaviors of Resident #1 as well as those Residents with documented behaviors and receiving psychiatric medication.
The SA validated through review of competency check sheets, the Rehab Director, RN and/or LPN staff completed competency checklist for Certified Nursing Assistants (CNAs) from 5/28/21 through 6/8/22 based on return demonstration and verbal demonstration on use of mechanical lift.
The SA validated through interviews with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 600}	Continued From page 31 Administrator, the Administrator and the DON reviewed the event and findings of Resident #2 and #14 with the Medical Director. The SA validated through review of the written disciplinary form and termination report, on CNA #3 was removed from the schedule on 5/4/21 and received a written disciplinary form for failure to use the mechanical lift as stated in the care plan for Resident #2. CNA #3 was terminated on 6/09/21. The SA validated through review of the written disciplinary form and termination report CNA #11 was suspended and later terminated due to not using the mechanical lift as stated in the care plan for Resident #14. The SA validated through interviews and review of QAPI sign in sheets, on the QAPI committee reviewed the policies in relation to abuse, neglect and misappropriate of property and use of Mechanical lift. All members agreed on the training plan and training will be provided to agency staff by contracted consultants if they do not have proof of education.	{F 600}		
{F 609} SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	{F 609}		7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 609}	Continued From page 32 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, facility policy reviews, and record reviews, the facility failed to report to the State Agency (SA) within two (2) hours, an incident of resident-to-resident abuse and failed to report to the SA within five days a finding of neglect after completion of an investigation of a major injury to a resident for two (2) of four (4) residents reviewed for abuse/neglect. Resident #6 and Resident #2. The facility's failure to report resident to resident abuse, when Resident #1 hit, pulled the hair of, and yelled at Resident #6 and the facility's failure to report within five days a finding of neglect after completion of an investigation of a fracture for Resident #2, placed all residents in a situation that caused or was likely to cause serious harm, serious injury, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) which began on	{F 609}	1. On 4/20/21 Resident #1 hit, pulled the hair, and threatened to kill Resident #6. On 5/6/2021 at 4:12 PM the administrator called the state complaint hotline to report the resident-on-resident abuse that Resident #1 hit, pulled the hair and threatened to kill Resident #6. On 5-6-21 the Regional Director of Operations performed an in-service and written corrective action on the Administrator concerning abuse and neglect to include reporting of alleged violations. Beginning 5/6/21 the Director of Nursing, Administrator and/or department managers conducted multiple mandatory in-services with all nurses (Registered Nurse, Licensed Practical Nurse, Certified Nurse Aides) and facility employees including abuse, neglect, and reporting abuse time frames. On 5/7/2021 at 4:27 PM the administrator faxed the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 609}	Continued From page 33 4/20/2021, when the facility failed to report the incident of Resident #1 hitting, pulling the hair of, and yelling at Resident #6. The facility Administrator was notified of the IJ on 05/06/2021 and the IJ template was given to the administrator at 3:15 PM. The IJ was not removed prior to the SA exit on 05/26/2021 and is considered ongoing. The IJ and Substandard Quality of Care (SQC) existed at CFR(s)483.12(c)(1) - Reporting of Alleged Violations The IJ was not removed prior to the State Agency (SA) exit on 5/26/2021 and was considered ongoing. The facility provided a Credible Removal Plan, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interviews and in-service sign-in sheets review. The facility provided evidence the facility had implemented corrective actions listed in the Credible Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for 42 CFR 483.45(f)(2) has been lowered from the scope and severity of a "K" to the scope and severity of an "E". The facility will remain out of compliance at Scope and Severity of "E" that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and	{F 609}	investigation findings to the state reporting line. On 4/27/21 Resident #2 was transferred to hospital for x-ray per MD orders. Daughter notified of incident on 5/4/21. Fractured Lt distal Upper 3 rd tibial diaphysis. On 4/28/21 the administrator called the state complaint hotline to report the injury because of being transferred without using a lift. The Administrator submitted the final investigation findings to the State Agency on 5/10/21 at 12:42pm via fax. 2. All residents have the potential to be affected by the deficit practice cited. 3. On 5/6/21, 5/8/21, and 5/21/21 the Quality Assurance Performance Improvement Committee met and reviewed the policies in relation to Abuse, Neglect and Misappropriate of Property and use of Mechanical lift. All members agreed on training plan. All staff including agency staff will have education done by facility management staff prior to working in our facility and annually. Beginning 5/6/21 the Regional Nurse and Administrator conducted multiple mandatory in-services with all nurses (RN, LPN, CNAs) and facility employees including abuse, neglect, aggressive behaviors. On 5/6/2021 at 3:52 PM an educational in-service on □Freedom from Abuse and Neglect and Reporting Abuse and Neglect was held by Regional Director of Operation (RDO) for Department Heads - Administrator, DON, Assistant Director of Nursing/Infection Control Coordinator (ADON/ICC), Maintenance Director, Human Resources/Business Office Manager	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 609}	Continued From page 34 Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: A review of the facility's policy, "Incident Report Checklist", undated, revealed " ... if the incident is reportable (i.e., resident on resident, inappropriate touching or sexual conduct, fall with significant injury, or unwitnessed/unexplainable injury) you must notify the Director of Nursing (DON) or the Administrator immediately as this has to be reported to the State Agency within one (1) hour of occurrence." A review of the facility's policy, "Accidents and Incidents" undated revealed ... " The Director of Nursing (DON) and or Administrator are notified of allegations of abuse or neglect and any injury of unknown origin at the time it is discovered ... Regardless of how minor an accident or incident may seem; it should be reported and an incident report form completed... Completed incident reports are forwarded to the Administrator or Director of Nurses for further review." The policy further revealed "Appropriate staff should be educated upon on hire and periodically thereafter regarding completing incident reports correctly and documenting in the medical records." A record review of the Quarterly MDS with and ARD of 4/8/21 for Resident #9, revealed A BIMS score of 15. Resident #6	{F 609}	(HR/BOM), Dietary Manager (DM), Medical Records Director, Social Service Director (SSD), Housekeeping Supervisor, Minimum Data Set Coordinator (MDS Coordinator). Beginning 5/23/21 mandatory in-services were conducted with all nursing staff (RN, LPN, CNA, Therapy staff) by Staff Educator concerning a case study of residents involved and policy on use of Mechanical Lift. The ADON/ICC and Nurse Consultant reviewed the current policy on Mechanical Lift for any needed revisions. No recommendation was made. Beginning 5/23/21 current staff completed competency checklist based on return demonstration or verbal demonstration on use of Mechanical lift. 4. The Nursing Home Administrator or Administrator in training will keep an incident log of potential abuse and reporting daily beginning 7/05/21. This will be an ongoing process. The Administrator or DON will review incidents daily for appropriate reporting, interventions, and care plans beginning 7/5/21. This will be an ongoing process. All incidents will be reviewed daily in clinical standup beginning 7/5/21. This will be an ongoing process. Findings will be brought to QAPI monthly beginning 7/2/21 for review, revision, or resolution of the plan. This will be an ongoing process. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance. The Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 609}	Continued From page 35 An interview on 05/02/2021 at 11:00 AM with Resident #6's daughter revealed she voiced her concern that her mother had been assaulted by another resident in the facility. On 05/5/2021 at 2:00 PM interview with Resident #6 revealed she is afraid of Resident #1. Resident #6 stated that Resident #1 hit her and pulled her hair on 4/20/21. Resident #6 stated Resident #1 continued to yell and scream at her and the other residents. Resident #6 stated if Resident #1 comes up to her again she is going to punch him before he can get to her because she is afraid of Resident #1. A record review of the progress notes dated 4/20/21 by Registered Nurse(RN) #3, revealed RN #3 was at the nurses station and heard Resident #6 say ,"do not touch my hair", She stated when she got up to see what was going on she saw Resident #1 by Resident #6 screaming, "I am going to kill your God D**n A**", Resident #1 repeated that statement several times to Resident #6 , then he walked down the hall. Resident #2 A review of anonymous Complaint #17774, received on 4/28/2021 by the SA, revealed Resident #2 was found to have a skin tear but no one had reported an accident. The report also stated later assessment done revealed bruising and edema. An x ray was completed, and the resident had a fracture of his left leg. An interview on 05/04/2021 with Resident #2's daughter revealed she had received a call from the Nurse Practitioner (NP) of the facility and was	{F 609}	beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 609}	Continued From page 36	{F 609}		

notified her father had a fracture and she was unsure what happened but thought the facility was investigating it.

Record review of a statement by CNA #2 revealed when she entered Resident #2's room, she observed, CNA #3 picking up the resident out of his wheelchair and placed him in the bed. During this time CNA #2 stated she heard a popping sound and question CNA #3 was that the resident's leg? CNA #2 stated that CNA #3 thought it was the bed that made the popping sound. CNA #2's statement revealed that CNA #3 stated, "Ain't nothing wrong with him", and then left the room.

During the interview with the Medical Nurse Practitioner (MNP) on 5/4/21 at 2:00 PM, revealed she was informed on 4/25/21 by the nurse that Resident #2 had a bad skin tear to the left lower leg. The MNP stated she called the Physician. She stated the Physician informed her to send the resident out for evaluation. The X-ray revealed an acute oblique fracture involving the distal 3rd of the left tibial diaphysis with slight lateral displacement of the distal fracture fragment. The MNP stated she talked to the Administrator and the Director of Nursing (DON) saying an investigation needed to be done. The MNP said she told the Administrator that she would have to report this to the State Agency (SA). The MNP said she called it in to the SA on the hotline as an anonymous complaint.

An interview on 5/6/21 at 3:00 PM with the Director of Nursing (DON) revealed the Assistant Director of Nursing (ADON) documented all the staff interviews regarding what happened the day the resident was injured. The DON said the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 609}	Continued From page 37	{F 609}		

Administrator finished the investigation and told her he reported it to the State Agency (SA). The DON said CNA #2 told her that CNA #3 transferred Resident #2 without a lift. Both CNAs were in the room. CNA #2 said she heard a popping sound and asked CNA #3 if that was the resident's leg. CNA #3 said no that was the bed. The DON stated CNA #2 did not tell anyone what happened. The DON said after she received a statement from CNA #2 the facility determined the fracture was caused by CNA #3 transferring the resident from the wheelchair to the bed without a lift. The DON stated it was her understanding the Administrator was supposed to report the incident to the SA.

A record review of Resident #2's Medical Diagnoses revealed Fracture of shaft of left fibula initial encounter for closed fracture, Lack of coordination, Muscle Wasting and Atrophy, Muscle Weakness, and Primary Osteoarthritis.

A record review of the local hospital discharge summary dated 4/27/21, revealed left tibia and fibula fracture.

A record review of the X-ray report from local hospital dated 4/27/21, revealed acute oblique fracture involving the distal 3rd of the left tibia diaphysis with slight lateral displacement of the distal fracture fragment. The joints are not involved.

On 5/20/21 at 2:00 PM, in an interview with the Administrator regarding reporting the incidents involving Resident #1 and Resident #6, he stated he had been an administrator in Louisiana and there he was told he did not have to report verbal abuse. The Administrator stated he was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 609}	Continued From page 38 aware Resident #1 had hit Resident #6 or that her hair was pulled until the SA investigated the complaint. The Administrator confirmed he had not reported Resident on Resident verbal abuse. Regarding the incident involving Resident #2, the Administrator stated he received a copy of Resident #2's X-ray reports and the completed investigation of the incident and was aware the resident sustained a fracture as a result of being transferred without a lift. The Administrator stated he did not report the final outcome of the investigation within 5 days of the incident. The Administrator stated he put a reminder on his calendar to send the final investigation of the incident but forgot to send it. Removal Plan: The failure to report within five days a finding of neglect after completion of an investigation of a fracture. Noncompliance at F609 has the potential to affect all residents in the Facility. On 4/20/21 Resident #1 hit, pulled the hair, and threatened to kill Resident #6. On 5/6/2021 at 4:12 PM the administrator called the state complaint hotline to report the resident-onresident abuse that Resident #1 hit, pulled the hair and threatened to kill Resident #6. On 5-6-21 the Regional Director of Operations performed an in-service and written corrective action on the Administrator concerning abuse and neglect to include reporting of alleged violations. Beginning 5/6/21 the Director of Nursing, Administrator and/or department managers conducted multiple mandatory in-services with all nurses (RN, LPN, CNAs) and facility employees including abuse, neglect, and reporting abuse time frames. On 5/7/2021 at 4:27 PM the administrator faxed the investigation findings to the state reporting	{F 609}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 609}	Continued From page 39	{F 609}		

line.
Resident #2 - Use of Mechanical Lift
On 4/27/21 Resident #2 was transferred to hospital for x-ray per MD orders. Daughter notified of incident on 5/4/21. Fractured Lt distal Upper 3rd tibial diaphysis.
On 4/28/21 at the administrator called the state complaint hotline to report the injury as a result of being transferred without using a lift.
The Administrator submitted the final investigation findings to the State Agency on 5/10/21 at 12:42 pm via fax.
Validation:

The State Survey Agency (SSA) validated through interviews and record reviews the allegation of resident-on-resident abuse with Residents #1 and #6.
The State Survey Agency (SSA) validated through interviews and record review of the hot line report that on 5/6/21 at 4:12 PM the Administrator called the state complaint hotline to report the resident -on-resident abuse that Resident #1 hit, pulled the hair and threatened to kill Resident #6.
The State Survey Agency (SSA) validated through the facility in-service sign in sheets and disciplinary action form, the Regional Director of Operations conducted an in-service and initiated a written corrective action to the Administrator on 5/6/21 and the DON concerning abuse and neglect, to include reporting of alleged violations.
The SSA validated through review of in-service sign in sheets, the Director of Nursing, Administrator and/or department managers conducted multiple in-services with all nurses (RN, LPN, CNA's) and facility employees regarding abuse, neglect, and the reporting of abuse time frames.
The SSA validated through review of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 609}	Continued From page 40 investigation, the Administrator faxed the investigation findings to the state reporting line at 4:27 PM on 5/7/21. The SA validated through interviews and record reviews, Resident #2 was transferred to the hospital for an x-ray per MD orders, the family was notified of the incident, and the resident was diagnosed with a fractured left distal Upper 3rd tibial diaphysis. The SSA validated through interviews and record reviews the Administrator called the state complaint hotline on 4/28/21 to report the injury as a result of Resident #2 being transferred without using a mechanical lift. The SSA validated through record review the Administrator submitted the final investigation for Resident #2 the findings to the State Agency on 5/10/21 at 12:42 PM via fax.	{F 609}		
{F 656} SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	{F 656}		7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 656}	Continued From page 41 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to develop and implement a comprehensive care plan for residents with behaviors, residents who received therapeutic medications, residents who used lifts for transfers, and residents who had pressure ulcers for 17 of 24 residents reviewed for care plans. Residents # #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13 #14#15, #16 and #17. The facility's failure to develop and implement resident care plans caused or was likely to cause serious injury, serious impairment, or death of the	{F 656}	1. On 6/3/21 the Wound Care Specialist began assisting with wound audits, wound care, training of staff, and assisting with care plans. All Resident□s listed have been thoroughly assessed & reassessed and Care plans updated by Interdisciplinary Team including Minimum Data Set Coordinator and Wound Care Nurse Specialist with recommendations completed on 6/6/21. Resident #1□s Behavior Assessment was completed on 5/5/21 and a Care Behavior Health Care plan was done indicating that the incident occurred on 5/4/21. Resident #2□s Care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 656}	Continued From page 42 residents. This situation was determined to be an Immediate Jeopardy (IJ), which began on 3/17/21 when an aggressive resident was admitted to the facility and subsequently assaulted another resident, and a comprehensive care plan was not implemented until 4/15/21 and the IJ determined to exist on 4/20/21. The IJ was not removed prior to exit on 5/26/21 and is considered ongoing. The IJ existed at §483.21(b) Comprehensive Care Plans §483.21(b)(1) The IJ was not removed prior to the State Agency (SA) exit on 5/26/2021 and was considered ongoing. The facility provided a Credible Removal Plan, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interviews and in-service sign-in sheets review. The facility provided evidence the facility had implemented corrective actions listed in the Credible Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for 42 CFR 483.45(f)(2) has been lowered from the scope and severity of a "K" to the scope and severity of an "E". The facility will remain out of compliance at Scope and Severity of "E" that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and	{F 656}	Plan was reviewed for use of mechanical lift by the MDS Coordinator on 5/5/21. No changes needed. CNA#3 did not follow Care Plan. On 5/21/21 care plan reviewed and revised again on 5/21/21. On 5/27/21 CNA #3 was removed from PRN (as needed) list and later terminated due to not following policy and or Resident□s care plan resulting in fracture of leg. Resident #3□s Care plan was updated to include the wound care clinic appointments, correct staging and current wound care orders for sacrum wound by the MDS Coordinator and Wound Care Nurse Specialist on 5/18/21. Resident #5□s Discharged on 1/21/21. No care plan to update due to discharge. Resident #6□s MDS updated care plan for wounds on 5/21/21, Certified Wound Care Nurse assessed resident for wounds on 5/23/21, no care plan revisions required after assessment. On 5/18/21 the MDS Coordinator correct the MDS dated 12/8/20 - no wounds were in Section M. Resident #7 - MDS Coordinator reviewed MDS dated 4/18/21. No MDS correction allowed as the documentation supplied with updated information on wounds was supplied outside of the allowed look back period to use for the MDS assessment per the RAI manual. Certified Wound Care Nurse assessed Resident #7 on 5/22/21, and on 5/24/21 MDS Coordinator updated care plan with correct number of wounds and treatment. Resident #12 □ Discharged on 5/17/21. No revisions to Section M of the 4/16/21 MDS are needed as the additional wounds noted occurred and were documented after the allowed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 656}	Continued From page 43 implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: The facility's, "Using the Care Plan" undated, read, it is the policy of this facility that the care plan be used in developing the resident's daily care routines. Daily care and documentation should be consistent with the resident's care plan. Resident #1 A review of the facility's Progress Notes dated 4/20/21 at 15:30, revealed Resident #1 was transferred to the local Behavior facility because of increased confusion/agitation. Resident #1 constantly pacing in hallway, cursing, yelling at staff and residents. Threatening to kill peers and is difficult to redirect. A review of the facility's Progress Notes dated 4/30/32 at 15:21 revealed Resident #1 returned to the facility with new orders for Alprazolam (mg) 0.5 milligrams orally daily for anxiety, Aricept 10 mg orally at bedtime for dementia, Buspirone HCL 10 mg orally twice a day for anxiety, Namenda 5 mg orally twice a day for dementia, Olanzapine 10 mg orally three times a day for psychosis and Seroquel 300 mg orally at bedtime for psychosis, Seroquel 25 mg po twice a day, Zyprexa 10 mg every 8 hours, Depakote 250 mg orally twice a day. On 5/4/21 at 1:14 PM Resident #1 was observed running up and down the hallway in the facility	{F 656}	assessment period per the RAI manual. Resident #13- Certified Wound Care Nurse assessed Resident #13 on 5/22/21. MDS Coordinator updated the care plan on 5/25/21. Resident # 14 □ Wound Care Nurse Specialist completed an assessment of Resident #14□s wounds on 5/27/21. The MDS Coordinator updated the care plan on 5/28/21 after resident returned from a hospital stay spanning 5/20/21 to 5/27/21 to include the treatment and intervention to the Stage 2 on the Buttocks. Resident #16 □ Care Plan was updated by MDS Coordinator. He was discharged on 06/09/21. Resident # 17□s - Certified Wound Care Nurse assessed the wound on 5/22/21 and MDS Coordinator updated the Care plan on 5/24/21 to include the correct staging of the wound on left heel. On 5/23/21 Residents #4, #8, #9, #10, #11, #15, & #16 Care Plans were assessed and updated with correct staging, treatment and interventions. On 6/03/21 Corporate Management approved for Wound Care Specialist from other facilities to work in the facility to assist with audits of wounds, wound care, training, and assist with correcting care plans. On 5/23/21 Charge Nurses, MDS Coordinator, and DON were in-serviced by the Regional Nurse due to failure to assess wounds weekly, update care plan when wounds change or develop care plan must be updated immediately. On 5/6/21 the Assistant Director of Nursing, MDS Coordinator and Regional Nurse reviewed all other Resident□s care plan for accuracy and updated the Care Plan information for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

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LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 656}	Continued From page 44 yelling, screaming, cursing, and threatening staff and other residents. Resident #1 approached the State Agency (SA) and poked her in the chest while screaming and cursing. Resident #1 was redirected by the facility Administrator. A review of the facility's Comprehensive Care Plan dated 4/15/21, revealed Resident #1 has impaired cognitive function/dementia or impaired thought process related to Dementia or impaired thought processes r/t Dementia, difficulty making decisions. Short- and long-term memory loss. The intervention was to engage the resident in simple, structured activities that avoid overly demanding tasks. Resident #1 also has an Activities of Daily Living (ADL) self-care performance deficit related to aggressive behavior and confusion. Resident #1 has the potential to be aggressive with staff and other residents related to anger, dementia, and poor impulse control. Resident #1's interventions used in the facility was to administer medications, analyze time of day, places, circumstances, assess, anticipate the resident's needs, triggers and what de-escalates behavior. Resident #1 has communication problems related to cognitive communication deficiency. The facility intervention is to cue, reorient and supervise as needed. Resident #1 has a mood problem related to known physiological condition with manic features. On 5/7/2021, at3:15 PM, in an interview with Registered Nurse (RN) #1 confirmed the facility failed to develop a behavior care plan to meet the individualized needs of Resident #1. RN #1 said she did not know what else to do with Resident #1. The local Behavioral health facility did not give recommendations except for the medication. RN #1 said the DON and Administrator said the	{F 656}	Behaviors, Skin issues and use of mechanical lift. 2. All residents have the potential to be affected by the deficit practice cited. 3. An audit was initiated on 5/24/21 by the MDS nurse for all patients with wounds, lifts, behaviors and medication care plans to ensure that all required comprehensive care plans were in place and up to date, any needed revisions were made at that time. The MDS Auditor Specialist also initiated an audit on care plans on 5/24/21 to ensure that care plans were up to date and in place, any findings were corrected and addressed with the facility MDS nurse and the Care Plan Committee for further education. 4. The DON or MDS nurse will audit five care plans monthly for accuracy and timeliness beginning 7/2/21 for six months. The IDT will meet weekly beginning 7/2/21 and review two residents care plans for updates, revisions and completeness. This will be an ongoing process. Findings will be brought to QAPI monthly beginning 7/2/21 for review, revision, or resolution of the plan for six months. Independent monitoring began 6/7/21by an outside consulting firm is being performed for compliance assistance. The Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 656}	Continued From page 45	{F 656}		

facility did not have enough staff to do a one on one. RN #1 revealed she has not had behavioral health training. RN #1 said all residents are assess for transfers. Sometimes the staff transfer the residents with lifts without recommendations from Therapy or without it being on the care plan. This is not the facility policy. The nurse confirmed Resident #1 care plan was not developed to meet Resident #1 individualized needs after his stay at the behavioral facility.

Resident #2

On 5/6/21 at 3:00 PM, in an interview with the Director of Nursing (DON), revealed the Assistant Director of Nursing (ADON) took the statements from all the nurses of what happened the day the Resident #2 was injured. The DON said CNA #2 told her that CNA #3 transferred Resident #2 without a lift. Both CNAs were in the room. CNA #2 said she heard a pop and asked CNA #3 if that was the resident's leg. CNA #3 said no that was the bed. The DON said after she received a statement from CNA #2 the facility determined the fracture was caused by the CNA #3 during transfer.

A record review of the facility's investigation related to Resident #2, revealed a statement from Certified Nursing Assistant (CNA) #3 stated, she did not notice any concerns while providing care to Resident #2 on 4/22/21. A review of a statement by CNA #2 revealed she entered Resident #2's room, CNA #3 picked up the resident and placed him in the bed. CNA #2's statement revealed she heard a pop sound and asked CNA #3 was that the resident's leg? CNA #2's statement revealed that CNA #3 thought it was the bed that made the popping sound.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 656}	Continued From page 46	{F 656}		

A record review of Resident #2 Admission Record revealed an admission date of 6/19/2020.

A record review of Resident #2 Diagnosis revealed lack of coordination and Muscle wasting and Atrophy, dated 7/30/2020.

A record review of the Comprehensive Care Plan revealed, Resident #2 has an Activities of Daily Living self-care performance deficit related to limited mobility, limited range of motion. The intervention stated use total lift to maximize independence with transferring.

A record review of the local hospital discharge summary dated 4/27/21, revealed left tibia and fibula fracture.
A record review of the X-ray report from local hospital dated 4/27/21, revealed acute oblique fracture involving the distal 3rd of the left tibia diaphysis with slight lateral displacement of the distal fracture fragment. The joints are not involved.

Resident #3

05/06/21 at 1:15 PM in an interview with Resident #3's daughter revealed her mother acquired the wound in the facility. The daughter said she hired a sitter to assist the resident because the staff was not turning her and assisting with meals.

0n 5/05/21 at 1:00 PM interview with LPN #5 she reported Resident #3 acquired the wound to her sacrum in the facility. The nurse said the resident acquired the wound before she started working at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 656}	Continued From page 47	{F 656}		

Record review for Resident #3's Admission Record revealed the facility initially admitted Resident #3 on 02/24/2019 with the diagnoses of Atrial Fibrillation, Type 2 Diabetes Mellitus, Pressure Ulcer Sacral Region Stage 3, Hemiplegia and Hemiparesis, Peripheral Vascular Disease, Cardiomegaly, and High Blood Pressure.

Record review Quarterly Minimum Data Set with Assessment Reference Date (ARD) dated for 2/15/21 Section H revealed Resident #3 was always incontinent of bowel and bladder. Section M revealed Resident #3 had a Stage 3 pressure ulcer.

Record review of Resident #3's care plans revealed the wound care plans do not include Wound Care Clinic appointments or new updated wound care orders for sacrum wound.

Record review of new updated care plans for Resident #3 on 05/14/2021 at 10:00 AM from RN #1 revealed the new updated care plans revealed no changes in care plan for Stage 3 wound and not a new care plan for new Stage 2 wound.

Resident #5

On 05/06/2021 at 9:00 AM in an interview with LPN #10, she explained she helped take care of Resident #5 while she was at the facility. She reported Resident #5 did have some wounds on admission, but she did develop other wounds while at the facility. She further reported the resident had her left leg contracted and was hard to have resident straighten leg out. She explained the resident would not wear heel protectors much, but staff would try and reapply.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 656}	Continued From page 48	{F 656}		

Record review of Resident #5's Admission Record revealed, the facility admitted Resident on 05/19/2020 with the diagnoses of Hypothyroidism, Major Depressive Disorder, Anorexia, Heart Failure, History of Transient Ischemic Attach (TIA) and Cerebral Infarction without Residual Deficits, High Blood Pressure, Chronic Kidney Disease, Type 2 Diabetes, Unspecified Urethral Stricture, female, Pressure Ulcer of right buttock Stage 2, and Pressure ulcer of left heel, unstageable.

Resident #5 had one (1) Stage 2 and one (1) unstageable wound. The latest Discharge MDS with ARD of 1/21/2021 revealed the same findings as the quarterly MDS.

Record review of Resident #5's Initial Weekly Wound Pressure report dated 05/20/2020 revealed resident #5 was admitted with wound left heel inner aspect unstageable with measurements 2 cm x 1.4 cm x 0.2 cm and wound to wound to right buttock and a Stage two (2) with measurements 1 cm x 1 cm x 0.2 cm. Review of Resident #5's nurse progress notes dated 05/25/2020 revealed a new area to left gluteal fold with partial thickness measurements of 1.5 cm x 0.5 cm x0.1 cm.

Record review of Resident #5's care plans revealed care plans for potential for impairment to skin integrity after it was identified Resident #5 had a left heel wound and a Stage II to her right buttock. The care plan was initiated on 06/04/2020 with interventions treatments as ordered, assess/record/monitor wound healing weekly measure length, width, and depth, type of tissue and exudate, and a care plan Resident #5 has pressure ulcer with not specified location or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 656}	Continued From page 49	{F 656}		

type of pressure ulcer with initiated date 09/17/2020 assess/record/monitor wound healing with missing specify frequency.

The record reviews of Resident #5's weekly wound audits and care plans revealed the facility failed to develop care plans to correlate with Resident #5's wounds.

Resident #6

Record review of Resident #6's Physician Orders revealed orders for date of 1/21/2021for a treatment to Resident #6's bilateral ankles that indicated change duoderm dressings to bilateral ankle abrasions every 3 days, fluff bilateral ankles with 4X4 gauze and ace wrap or wrap with Kerlix, check dressing daily to ensure appropriate coverage of wounds.

Record review of Resident #6's Annual MDS with ARD date 2/26/2021 Section M revealed Resident #6 had a Pressure ulcer of 1 or greater or a scar over a bony prominence. Section M had no other areas flagged for skin conditions.

Record review of Resident #6's weekly body audit dated for dated 03/03/2021, revealed right and left ankles with both wounds measuring 1.0 cm x 1.0 cm with callous like wound on ankles.

A record review of Resident #6's care plans revealed resident had pressure ulcers to bilateral outer ankles that was initiated on 04/29/2021 with interventions to administer treatments as ordered and assess/record/monitor wound healing weekly measure length, width, and depth. Care plans for Resident #6's wound was not developed when the wounds were initially identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 656}	Continued From page 50	{F 656}		

Resident #7

Record review of Resident #7's Face Sheet revealed the Facility initially admitted on 9/4/2018 and readmitted on 4/13/2021 with the following Medical Diagnoses include Type 2 Diabetes Mellitus, Heart Failure, Cardiomegaly, Cerebral Infarction, and Essential Hypertension.

Record review of the Discharge Minimum Data Set (MDS) dated April 18, 2021 Section M of the MDS revealed Resident #7 had only one Stage 3 wound.

Review of weekly body audit for Resident #7 revealed a sacrum wound Stage 3 with measurements 3 cm x 7 cm x 0.2 cm with bright red granulation tissue. The next body audit dated for 12/17/2020 with sacrum wound and no measurements. A weekly body audit noted for 03/16/2021 with sacrum wound measuring 3.5 cm x 1.8 cm x 0.2 cm. A weekly body audit noted for 04/13/2021 revealed new pressure ulcer to right buttock with no measurements.

Record review of weekly skin reports provided by the DON revealed wound measurements for Resident #7 on 03/15/21 facility acquired Stage 2 sacrum 1.8 cm x 3.5 cm and 0.1 cm and on 05/08/2021 stage 3 sacrum with 1.5 cm x 1 cm x 0.1 cm stage 3.

Record review of Resident #7's care plans printed on 05/07/2021 revealed a care plan initiated on 09/06/2018 and revised on 04/26/2021 resident has a potential for altered skin integrity related to immobility and incontinent episodes of bowel with goal to have no complications related to Stage 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 656}	Continued From page 51	{F 656}		

ulcer and interventions for weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue, and exudate. These records are inconsistence with wound measurements observed by the DON and SA.

Resident #12

Record review of Face Sheet revealed the facility initially admitted Resident #12 on 10/24/2021 and readmitted on 1/6/2021 with diagnoses that included Pressure ulcer of right buttock Stage 2 and Non-pressure chronic ulcers skin.
Record review of the Quarterly Minimum Data Set (MDS) dated April 16, 2021, Section M of the MDS revealed Resident #12 had one Stage 2 ulcer.

Record review of Resident #12's Physician Orders with a start date of 12/31/20 revealed orders for A and D ointment to buttock topically two times a day with Nystatin and triamcinolone with start date, hydrogel apply to Stage 2 buttock topically two times a day for decubitus buttock. and a new order on 05/10/2021 for zinc oxide apply to buttocks. An order with start date 01/01/2021 noted clean bilateral knees with normal saline, pat dry apply Promogran to wound beds, secure with border gauze and changer every 48 hours, and another order with start date 04/20/2021 cleanse wound to left and right anterior knee with normal saline, pat dry, apply Silvadene to wound bed and cover with a border dressing one time a day for wound care.

On 5/6/21 at 2:55 PM, the SA observed the DON do a full body audit on Resident #12. The full body audit with the DON revealed one ulcer to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 656}	Continued From page 52	{F 656}		

both anterior knees and left lower lateral leg above the ankle and an ulcer to left lateral lower leg. An assessment of the buttocks revealed three (3) open areas to right buttock and one (1) open area to left buttock.

On 5-13-21 at 9:30 AM in an interview with Wound Care Clinic Nurse, RN #2, She explained Resident #12 was seen at the wound care clinic She explained Resident #12 was readmitted to the wound care clinic on 12/21/2020 from the facility. She reported Resident #12 was treated on 01/07/2021 for a pressure ulcer to right buttock which was acquired at the facility and the resident had reported to her the wound had been there for about two (2) weeks.
Record review of Resident #12's care plans revealed a start date of 04/14/2021 resident has a Stage 2 ulcer of the heel with interventions to assess/record/monitor wound healing two times weekly measure length, width, and depth.
Records review of Physician Orders and wound reports reveal no wound to Resident #12's heels. Resident #12 never had a wound documented to his heels. Record review of Resident #12's care plans revealed no care plans were developed for Resident #12's actual wounds to his heels, knees, lower leg or buttocks.

Resident #13

Observation on 05/06/21 at 10:00 AM, revealed LPN #6 provide wound care to Resident #13's left heel. The nurse cleansed the left heel with wound cleanser, applied Santyl and covered with kerlix. The wound was open and pink in the middle of the wound bed.

Record review for Resident #13's Admission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 656}	Continued From page 53	{F 656}		

Record revealed the facility admitted Resident #13 initially on 04/04/2018 and readmitted on 11/30/2020 with diagnoses that included Pressure ulcer of left heel Stage 2 on 04/16/2021.

Record review of Resident #13's Physician Orders revealed order for heel protectors bilaterally due to skin breakdown on left heel start date 12/31/2020 ...An order to inspect resident feet daily was started on 04/14/2021.
Record review of Resident #13's Quarterly MDS with ARD date 04/28/2021 revealed Section M revealed Resident #13 had one Stage 2 pressure ulcer.

Record review of Resident #13's care plans printed 05/14/2021 revealed a care plan for resident refusing heel protectors and floating heels on pillows with date initiated 05/11/2021 and resident has a Stage 2 left heel pressure ulcer related to immobility and noncompliance with heel protectors with wound care orders and assess/record/monitor healing weekly, measure length, width, and depth. Care plans were not developed for Resident #13's wound with interventions to inspect resident feet daily when the wound was identified.

Resident #14

Record review of Resident #14's Admission Record revealed the facility initially admitted Resident #14 on 05/20/2015 and readmitted on 08/14/2018 with a diagnosis that included Stage 2 pressure ulcer unspecified buttock 01/29/2021.

Record review of Resident #14's Quarterly MDS with ARD date of March 1, 2021, Section M of the MDS revealed Resident #14 had no pressure,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 656}	Continued From page 54	{F 656}		

venous, or arterial ulcers, but did have moisture associated skin damage.
Record review of Resident #14's Physician Orders printed 05/10/2021 revealed orders for ensure hydrocolloid dressings are applied to left and right great toes and coccyx ulcers as ordered.

Record review of Resident #14's care plans revealed a care plan was initiated on 01/07/2021 for resident has ulcer to coccyx and left and right great toes but did not include a care plan for a Stag 2 to the buttocks.

Resident #17

Record review of Resident #17's Admission Record revealed the Facility originally admitted Resident #17 on 3/4/2021 and readmitted on 3/10/2021 with the Medical Diagnoses of Osteomyelitis of Vertebra, Sacral and Sacrococcygeal Region, Unstageable Pressure Ulcer of Sacral Region, Congestive Heart Failure, Diabetes Mellitus due to Underlying Condition with Foot Ulcer.

Record review of Resident #17's 5-day Minimum Data Set (MDS) with ARD of March 12, 2021, revealed Section M of the MDS revealed Resident #17 had one unstageable wound due to non-removable dressing/device and one unstageable wound due to slough or eschar diabetic foot ulcer and other open lesions on the foot.

Record review of Resident #17's nurse progress notes revealed on admission 03/04/2021 Resident #17 had a wound present to sacrum, three incision scars near umbilical area, wound to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 656}	Continued From page 55 left heel, and black scar tissue visible to toes. Record review of a Baseline care plans dated 03/04/2021 revealed the Baseline care plan was incomplete. Record review of Resident #17's care plans printed 05/17/2021 revealed a care plan for resident has infection of the sacrum related to Stage 4 pressure ulcer of the sacrum/refuses diaper change and care. The care plan was initiated on 05/08/2021 with interventions administer antibiotic as ordered, maintain peripherally inserted central catheter (PICC) dressing changes and flush before and after IV antibiotics, monitor PICC site for signs and symptoms of infection, monitor/document/ report to physician sign and symptoms of delirium. Resident #17 had only one care plan for wound care initiated on 05/05/2021. The care plan explained resident has potential for impairment to skin integrity of all pressure points related to contact dermatitis, fragile skin, and infection of sacral wound with interventions encourage good nutrition, follow facility protocols for treatment of injury, monitor/document location, size, by the DON with description of pressure wound Stage 2 with eschar to left heel with measurements of length 5 cm and width 5 cm. Removal Plan: All Resident's listed have been thoroughly assessed & reassessed and Care plans updated by Interdisciplinary Team including MDS Coordinator and Wound Care Nurse Specialist with recommendations completed on 6/6/21. On 6/6/21 Resident #1's Behavior Assessment was completed on 5/5/21 and a Care Behavior Health Care plan was done indicating that the	{F 656}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 656}	Continued From page 56 incident occurred on 5/4/21. Resident #2's Care Plan was reviewed for use of mechanical lift by the MDS Coordinator on 5/5/21. No changes needed. CNA#3 did not follow Care Plan. On 5/21/21 care plan reviewed and revised again on 5/21/21. On 5/27/21 CNA #3 was removed from PRN list and later terminated due to not following policy and or Resident's care plan resulting in fracture of leg. Resident #3's Care plan was updated to include the wound care clinic appointments, correct staging and current wound care orders for sacrum wound by the MDS Coordinator and Wound Care Nurse Specialist on 5/18/21. Resident #5's Discharged on 1/21/21. No care plan to update due to discharge. Resident #6's MDS updated care plan for wounds on 5/21/21, Certified Wound Care Nurse assessed resident for wounds on 5/23/21, no care plan revisions required after assessment. On 5/18/21 the MDS Coordinator correct the MDS dated 12/8/20 no wounds were in Section M. Resident #7 - MDS Coordinator reviewed MDS dated 4/18/21. No MDS correction allowed as the documentation supplied with updated information on wounds was supplied outside of the allowed look back period to use for the MDS assessment per the RAI manual. Certified Wound Care Nurse assessed Resident #7 on 5/22/21, and on 5/24/21 MDS Coordinator updated care plan with correct number of wounds and treatment. Resident #12 - Discharged on 5/17/21. No revisions to Section M of the 4/16/21 MDS are needed as the additional wounds noted occurred and were documented after the allowed assessment period per the RAI manual.	{F 656}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 656}	Continued From page 57	{F 656}		

On 5/14/21 the MDS Coordinator and Wound Care Nurse Specialist assessed Resident #12 wounds and updated care plan to include wounds on heels, knees lower leg and buttocks. Remove as this did not occur resident passed away on 5/17/21.
Resident #13- Certified Wound Care Nurse assessed Resident #13 on 5/22/21. MDS Coordinator updated the care plan on 5/25/21.
Resident # 14 - Wound Care Nurse Specialist completed an assessment of Resident #14's wounds on 5/27/21. The MDS Coordinator updated the care plan on 5/28/21 after resident returned from a hospital stay spanning 5/20/21 to 5/27/21 to include the treatment and intervention to the Stage 2 on the Buttocks.
Resident #16 - Care Plan was updated by MDS Coordinator. He was discharged on 06/09/21.
Resident #17's - Certified Wound Care Nurse assessed the wound on 5/22/21 and MDS Coordinator updated the Care plan on 5/24/21 to include the correct staging of the wound on left heel.
Residents #4, #8, #9, #10, #11, #15, & #16 Care Plans were assessed and updated with correct staging, treatment and interventions.
On 6/03/21 Corporate Management approved for Wound Care Specialist from other facilities to work in the facility to assist with audits of wounds, wound care, training, and assist with correcting care plans.
On 5/23/21 Charge Nurses, MDS Coordinator, and DON were in-serviced by the Regional Nurse due to failure to assess wounds weekly, update care plan when wounds change or develop care plan must be updated immediately.
On 5/6/21 the ADON, MDS Coordinator and Regional Nurse reviewed all other Resident's care plan for accuracy and updated the Care Plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 656}	Continued From page 58	{F 656}		

information for Behaviors, Skin issues and use of mechanical lift.
Validation:
Resident #5 and Resident #12 are not included in the validation due to residents discharged.
The State Survey Agency (SA) validated through review of sign-in sheets and interviews with licensed nurses the Nurse Consultant conducted in-services for charge nurses, the MDS Coordinator, and the Director of Nursing (DON) regarding developing and implementing comprehensive care plans for wound care, medications, and lift transfer usage and regarding assessing wounds weekly and immediately updating and/or
developing care plans based on the weekly wound assessments.
The SA validated through review of sign-in sheets and interviews with Certified Nursing Assistants (CNAs) the Assistant Director of Nursing (ADON) conducted an in service on the usage of care plans.
The SA validated through record reviews and interviews the Psychiatric Nurse Practitioner completed a Behavior Assessment and the MDS Coordinator completed a Behavior Health Care Plan for Resident #1.
The SA validated through review of the Comprehensive Care Plan and interview with MDS Coordinator Resident #2 care plan was reviewed and revised regarding use of mechanical lift.
The SA validated through record review of the PRN staffing list and CNA termination report CNA #3 was removed from PRN list and has been terminated.
The SA validated through record review and interviews the Comprehensive Care Plan for Resident #3 was updated to include the wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 656}	Continued From page 59	{F 656}		

care clinic appointments, correct staging and current wound care orders for sacrum wound by the MDS Coordinator and Wound Care Nurse Specialist.
The SA validated through record reviews and interviews the Certified Wound Care Nurse completed a Pressure Wound Assessment and the MDS Coordinator updated the Comprehensive Care Plan for Resident #6 to include wounds.
The SA reviewed the MDS dated 12/8/20 to validate wounds were included in Section M.
The SA validated through record review of the Pressure Wound Assessment, the Comprehensive Care Plan, and interviews with the Certified Wound Care Nurse and the MDS Coordinator, Resident #7 was assessed for wounds and the MDS Coordinator updated the care plan with the correct number of wounds and treatment.
The SA validated through record review of the Pressure Wound Assessment, the Comprehensive Care Plan, and interviews with the Certified Wound Care Nurse and the MDS Coordinator, Resident #13 was assessed for wounds and the MDS Coordinator updated the care plan to include wounds.
The SA validated through record review of the Pressure Wound Assessment, the Comprehensive Care Plan, and interviews with the Wound Care Nurse Specialist and MDS Coordinator, Resident #14 was assessed for wounds and the MDS Coordinator updated the care plan to include the treatment and intervention to the Stage 2 on the Buttocks.
The SA validated through review of the Comprehensive Care Plan and an interview with the MDS Coordinator, Resident #16's care plan was updated by the MDS Coordinator prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 656}	Continued From page 60 discharge. The SA validated through record review of the Pressure Wound Assessment, the Comprehensive Care Plan, and interviews with the Certified Wound Care Nurse and the MDS Coordinator, Resident #17 was assessed for wounds and the MDS Coordinator updated the care plan to include the correct staging of the wound on the left heel. The SA validated through review of Comprehensive Care Plans and an interview with the MDS Coordinator Residents #4, #8, #9, #10, #11, #15, & #16 care plans were reviewed and updated with correct staging, treatment, and interventions. The SA validated through interview with Senior Director of Operations and current wound care specialist for other facility that Corporate Management approved for Wound Care Specialist from other facilities to work in the facility to assist with audits of wounds, wound care, training, and assist with correcting care plans. The SA validated through review of an audit form completed by the ADON, MDS Coordinator, and Regional Nurse all Residents care plans were reviewed for accuracy and care plan information was updated to include Behaviors, Skin issues, and use of mechanical lift.	{F 656}		
{F 657} SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	{F 657}		7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 657}	Continued From page 61 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to revise comprehensive care plans to meet individual needs for residents with pressure ulcers, residents receiving therapeutic medications and for a resident who returned from Behavioral Health for (14) of (24) care plans reviewed. Resident #1, #2, #3, #4, #5, #7, #8, #9, #10, #11, #12, #15, #16 and #17. The facility's failure to revise care plans caused or was likely to cause serious injury, serious impairment, or death of the residents. This situation was determined to be an	{F 657}	1. On 5/23/21, the Charge Nurses, Minimum Data Set Coordinator, and Director of Nursing were in-serviced regarding a failure to assess wounds weekly, and immediately update or develop care plans when wounds change. On 5/23/21 Residents #4, #8, #9, #10, #11, #15, & #16□s Care Plans were assessed and updated with correct staging, treatment and interventions and Therapeutic medications. Resident #1□s behavior assessment was completed on 5/5/21 and a behavior health care plan was completed indicating that the incident occurred on 5/4/21. Resident #2 Care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 62 Immediate Jeopardy (IJ) on 05/21/2021 and was determined to exist on 11/17/2020 when a resident with COVID-19's plan of care was not reviewed or revised for ordered medications for COVID-19. The IJ was not removed prior to exit on 05/26/2021 and is considered ongoing. The IJ existed at 483.21(b) Comprehensive Care Plans §483.21(b)(2) The IJ was not removed prior to the State Agency (SA) exit on 5/26/2021 and was considered ongoing. The facility provided a Credible Removal Plan, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interviews and in-service sign-in sheets review. The facility provided evidence the facility had implemented corrective actions listed in the Credible Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for 42 CFR 483.45(f)(2) has been lowered from the scope and severity of a "K" to the scope and severity of an "E". The facility will remain out of compliance at Scope and Severity of "E" that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility	{F 657}	Plan was reviewed for use of mechanical lift by the MDS Coordinator on 5/5/21; no changes needed. Certified Nurse Aide#3 did not follow Care Plan. On 5/21/21, the care plan was reviewed and revised. On 5/27/21, CNA #3 was removed from PRN (as needed) list and later terminated because he/she did not follow policy and/or Resident□s care plan resulting in Resident□s injury. Resident #3□s Care plan was updated by the MDS Coordinator and Certified Wound Care Nurse to include the wound care clinic appointments, correct staging, and current wound care orders for sacrum wound on 5/18/21. Resident #5 was discharged on 1/21/21. No care plan to update due to discharge. Resident #6 On 5/18/21, the MDS Coordinator correct the MDS dated 12/8/20 - no wounds were in Section M. MDS Coordinator updated care plan for wounds on 5/21/21. Certified Wound Care Nurse assessed Resident for wounds on 5/23/21; no care plan revisions required after assessment. Resident #7 The MDS Coordinator reviewed MDS dated 4/18/21. No MDS correction was allowed as the documentation supplied with updated information on wounds was supplied outside of the allowed look back period to use for the MDS assessment per the RAI manual. Certified Wound Care Nurse assessed Resident #7 on 5/22/21. On 5/24/21, MDS Coordinator updated the care plan with correct number of wounds and treatment. Resident #12 Discharged on 5/17/21. No revisions to Section M of the 4/16/21 MDS are needed as the additional wounds noted occurred and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 63 sustains compliance with regulatory requirements. Findings include: The facility's, "Care Plan Comprehensive Policy Statement" undated, read, the facility will develop the comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs. Care plans are revised as changes in the resident's condition dictates. Reviews are made at least quarterly. The Care Planning Committee/Team is responsible for maintaining care plans in a current status. Resident # 1 Record review of Resident #1's Admission Record revealed Resident #1 was admitted to the facility on 3/17/2021. Record review of Resident #1 Diagnosis Information included Unspecified Dementia with Behavioral Disturbance, Epilepsy, Cognitive Communication Deficit, Generalized Anxiety Disorder, Mood Disorder with Known Physiological Condition with Manic Features, Hypothyroidism, and Angina Pectoris. Record review of the Admission Minimum Data Set (MDS) dated 3/23/2021, revealed a Brief Interview of Mental Status (BIMS) score of 00, indicating that Resident #1 has severe impairment in cognition. Record Review revealed that Resident #1 had a physician order dated 4/30/21 for Levothyroxine Sodium Tablet 75 micrograms (mcg) by mouth	{F 657}	were documented after the allowed assessment period per the RAI manual. Resident #13- Certified Wound Care Nurse assessed Resident #13 on 5/22/21. MDS Coordinator updated the care plan on 5/25/21. Resident # 14 □ DON completed an assessment of Resident #14□s wounds on 5/27/21. The MDS Coordinator updated the care plan on 5/28/21 after Resident returned from a hospital stay spanning 5/20/21 to 5/27/21 to include the treatment and intervention to the Stage 2 on the Buttocks. Resident # 17□s - Certified Wound Care Nurse assessed the wound on 5/22/21 and MDS Coordinator updated the Care plan on 5/24/21 to include the correct staging of the wound on left heel and therapeutic medications. On 6/03/21 Corporate Management approved for Wound Care Specialists from other facilities to work in the facility to assist with audits of wounds, wound care, training, and assist with correcting care plans. On 5/6/21, the ADON, MDS Coordinator, and Regional Nurse reviewed all other Resident□s care plan for complete and accurate information for behaviors, skin issues and therapeutic medications. Care plans were updated for residents for whom their care plans were not accurate. The Care Plan Committee implemented comprehensive care plans for Residents #2, 3, 6, 7, 9, 10, 11, 14, 15, 17, 20, 30, and 31 on 5/21/2021 related to lifts, wounds, and medications. Residents # 4, 5, 12, and 16 are discharged so changes to the care plan could not be made. 2. All residents with skin integrity	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 657}	Continued From page 64 one time daily for thyroid. Record review of Resident # 1's comprehensive care plan revealed there was no care plan (focus, goals, or interventions) in place for the thyroid diagnosis, including medications (Levothyroxine Sodium) and labs. Record review of the facility's Progress Notes dated 4/20/21 at 15:30, revealed Resident #1 was transferred to the local Behavior facility because of increased confusion/agitation. Resident #1 constantly pacing in hallway, cursing, yelling at staff and residents. Threatening to kill peers and is difficult to redirect. Record review of the facility's Progress Notes dated 4/30/32 at 15:21, revealed Resident #1 returned to the facility with new orders for Alprazolam (mg) 0.5 milligrams orally daily for anxiety, Aricept 10 mg orally at bedtime for dementia, Buspirone HCL 10 mg orally twice a day for anxiety, Namenda 5 mg orally twice a day for dementia, Olanzapine 10 mg orally three times a day for psychosis and Seroquel 300 mg orally at bedtime for psychosis, Seroquel 25 mg po twice a day, Zyprexa 10 mg every 8 hours, Depakote 250 mg orally twice a day. On 5/421 at 1:14 PM Resident #1 was observed running up and down the hallway in the facility yelling, screaming, cursing, and threatening staff and other residents. Resident #1 approached the State Agency (SA) and poked her in the chest while screaming and cursing. Resident #1 was redirected by the facility Administrator. A review of the facility's Comprehensive Care Plan dated 4/15/21, revealed Resident #1 has	{F 657}	concerns have the potential to be affected by the deficit practice cited. 3. An audit was initiated on 5/21/21 by the MDS nurse for all residents with wounds, lifts, behaviors and medication care plans to ensure that all required comprehensive care plans were in place and up to date. Any necessary revisions were made at that time. The MDS Auditor Specialist initiated an audit on care plans on 5/24/21 to ensure that care plans were up to date and in place. Any findings were corrected and addressed with the facility MDS Nurse and the Care Plan Committee for further education. 4. The DON or MDS nurse will audit five care plans monthly beginning 7/1/21 for accuracy and timeliness. The IDT will meet weekly beginning 7/1/21 and review two residents care plans for updates, revisions and completeness. This will be an ongoing process. Beginning 7/2/21 findings will be brought to QAPI monthly for review, revision, or resolution of the plan for six months. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance. The Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 65	{F 657}		

impaired cognitive function/dementia or impaired thought process related to Dementia or impaired thought processes r/t Dementia, difficulty making decisions. Short- and long-term memory loss. The intervention was to engage the resident in simple, structured activities that avoid overly demanding tasks. Resident #1 also has an Activities of Daily Living (ADL) self-care performance deficit related to aggressive behavior and confusion. Resident #1 has the potential to be aggressive with staff and other residents related to anger, dementia, and poor impulse control. Resident #1's interventions used in the facility was to administer medications, analyze time of day, places, circumstances, assess, anticipate the resident's needs, triggers and what de-escalates behavior. Resident #1 has communication problems related to cognitive communication deficiency. The facility intervention is to cue, reorient and supervise as needed. Resident #1 has a mood problem related to known physiological condition with manic features.

Resident #2
Record review of the Admission Record revealed Resident #2 was admitted to the facility on 6/19/2020.

Record review of Resident #2's Diagnosis Information included Type 2 Diabetes Mellitus, Chronic Embolism with Thrombosis, Unspecified Fracture of Shaft of Left Fibula, Atherosclerotic Heart Disease, Pressure Ulcer of Sacral Region, and Chronic Kidney Disease.

Record Review of the Physician orders reveals that Resident #2 had the following Physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 657}	Continued From page 66 Orders: 1. Eliquis 5 MG Give 5 mg by mouth two (2) times a day for anticoagulant (Ordered 6/18/20) 2. Metformin Hcl 500 mg Give by mouth one (1) tablet two (2) times a day for Type 2 diabetes (Ordered 8/6/2020) Record review of Resident # 2's comprehensive care plan revealed there was no care plan (focus, goals, or interventions) in place for the Chronic Embolism with Thrombosis diagnosis, including medications (Eliquis) and labs or no care plan (focus, goals, or interventions) in place for Type 2 diabetes diagnosis, including medications (Metformin) and labs. Resident #3 05/06/21 at 1:15 PM in an interview with Resident #3's daughter revealed her mother acquired the wound in the facility. The daughter said she hired a sitter to assist the resident because the staff was not turning her and assisting with meals. 0n 5/05/21 at 1:00 PM interview with LPN #5 she reported Resident #3 acquired the wound to her sacrum in the facility. The nurse said the resident acquired the wound before she started working at the facility. Record review for Resident #3's Admission Record revealed the facility initially admitted Resident #3 on 02/24/2019 with the diagnoses of Atrial Fibrillation, Type 2 Diabetes Mellitus, Pressure Ulcer Sacral Region Stage 3, Hemiplegia and Hemiparesis, Peripheral Vascular Disease, Cardiomegaly, and High Blood Pressure.	{F 657}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 657}	Continued From page 67	{F 657}		

Record review Quarterly Minimum Data Set with Assessment Reference Date (ARD) dated for 2/15/21 Section H revealed Resident #3 was always incontinent of bowel and bladder. Section M revealed Resident #3 had a Stage 3 pressure ulcer.

Record review of Resident #3's care plans the wound care plans do not include Wound Care Clinic appointments or new updated wound care orders for sacrum wound.
Record review of new updated care plans for Resident #3 on 05/14/2021 at 10:00 AM from RN #1 revealed the new updated care plans revealed no changes in care plan for Stage 3 wound and not a new care plan for new Stage 2 wound.

Resident #4

Record review of the Admission Record revealed Resident #4 was admitted to the facility on 8/15/2017 and readmitted on 10/27/2020.
Record review of Resident #4's Diagnosis Information included COVID-19, Heart Failure, Type 2 Diabetes Mellitus, Recurrent Major Depressive Disorder, Acute Kidney Failure, Chronic Obstructive Pulmonary Disease, and Anxiety Disorder.

On 11/17/2020, Resident #4 tested positive for COVID-19 and the Physician ordered the following medications:

1. Azithromycin Tablet 250 Give 500 milligrams (MG) by mouth one time a day for infection for one (1) day

2. Dexamethasone Tablet 6 MG Give 1 tablet by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 68	{F 657}		

mouth one time a day for COVID-19 for 10 days
3. Zinc Sulfate Capsule 20 Mg Give 1 capsule by mouth two times a day for COVID-19
4. Famotidine Tablet 40 MG Give 2 tablets by mouth three times a day for COVID-19 for 30 days
Resident #4 was transferred to the hospital Emergency Room for evaluation on 11/29/2020 and subsequently died.

Record review of Resident # 4's comprehensive care plan revealed there was no care plan (focus, goals, or interventions) in place for Covid-19 diagnosis, including medications (Azithromycin, Dexamethasone, Zinc, and Famotidine).
Resident #5
On 05/06/2021 at 9:00 AM in an interview with LPN #10, she explained she helped take care of Resident #5 while she was at the facility. She reported Resident #5 did have some wounds on admission, but she did develop other wounds while at the facility. She further reported the resident had her left leg contracted and was hard to have resident straighten leg out. She explained the resident would not wear heel protectors much, but staff would try and reapply.

Record review of Resident #5's Admission Record revealed, the facility admitted Resident on 05/19/2020 with the diagnoses of Hypothyroidism, Major Depressive Disorder, Anorexia, Heart Failure, History of Transient Ischemic Attach (TIA) and Cerebral Infarction without Residual Deficits, High Blood Pressure, Chronic Kidney Disease, Type 2 Diabetes, Unspecified Urethral Stricture, female, Pressure Ulcer of right buttock Stage 2, and Pressure ulcer of left heel, unstageable.

Record review of Resident #5's Quarterly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 69	{F 657}		

Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of November 16, 2020, revealed Section M of the MDS revealed Resident #5 had one (1) Stage 2 and one (1) unstageable wound. The latest Discharge MDS with ARD of 1/21/2021 revealed the same findings as the quarterly MDS.

Record review of Resident #5's care plans revealed care plans for potential for impairment to skin integrity with an initiation date of 06/04/2020. Resident #5 has a Stage II to her right buttock and an unstageable wound to left heel with an initiation date of 06/04/2020 with interventions treatments as ordered, assess/record/monitor wound healing weekly measure length, width, and depth, type of tissue and exudate, and a care plan Resident #5 has pressure ulcer with not specified location or type of pressure ulcer with an initiation date of 09/17/2020 assess/record/monitor wound healing with missing specify frequency.

The record reviews of Resident #5's Physician Orders, body audits, and care plans revealed the facility failed to revise and update care plans while Resident #5 was at the facility.
Resident #7

Record review of the Admission Record revealed Resident #7 was initially admitted on 9/4/2018 and readmitted on 4/13/2021.
Record review of Resident #7's Diagnosis Information included Type 2 Diabetes Mellitus, Heart Failure, Cardiomegaly, Cerebral Infarction, and Essential Hypertension.

Record Review of Resident #7's Physician Orders revealed the following Physician Orders:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 70 1. Xarelto Tablet 20 MG Give 1 tablet by mouth one time a day for Atrial Fibrillation with supper (Ordered 8/24/20) 2. Allopurinol Tablet 300 mg Give one (1) tablet by mouth one time a day for Gout (Ordered 04/22/2021) Review of Resident #7's Admission Record revealed that the resident has Atrial Fibrillation (a h Record review of Resident # 7's comprehensive care plan revealed there was no care plan (focus, goals, or interventions) in place for Atrial Fibrillation diagnosis, including medications (Xarelto) and labs. Also revealed there was no care plan in place for Gout diagnosis, including medications (Allopurinol) and labs. Observation on 5/21/21 at 2:30 PM, observed Resident #7 had two bandages intact, one to the sacrum and one to the right hip. The SA observed the DON remove the edges of the bandages and measure each wound for Resident #7's wound to right hip 1.5 cm x 7.0 cm x 0.25 cm, new wound noted to right gluteal fold 0.5 cmx 1.25 cm x 0.1 cm, and wound to sacrum 10 cm x 7 cm. The DON did not measure the depth of the sacrum wound. Moderate amount of purulent drainage with odor noted. Record review of Resident #7's care plans printed on 05/07/2021 revealed a care plan initiated on 09/06/2018 and revised on 04/26/2021 resident has a potential for altered skin integrity related to immobility and incontinent episodes of bowel with goal to have no complications related to Stage 3 ulcer and interventions for weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue, and exudate. These records are inconsistence with wound measurements	{F 657}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 71	{F 657}		

observed by the DON and SA on 5/21/21 at 2:30 PM.

Resident #8

Record review the Admission Record revealed Resident #8 was initially admitted to the facility on 8/8/2019 and readmitted on 11/28/2020.

Record review of Resident #8's Diagnosis Information included, Type 2 Diabetes Mellitus, Congestive Heart Failure, Cerebral Vascular Accident, Encephalopathy, Local Infection of the Skin and Subcutaneous Tissue, and Recurrent Major Depression Disorder.

Physician orders reveals that Resident #8 had the following Physician Orders:
1. Jardiance 25 mg by mouth one (1) time a day related to Type 2 Diabetes Mellitus (Ordered 4/7/20)
2. Lantus Solution 100 unit/mL 30 units subcutaneously one (1) time a day related to Type 2 Diabetes Mellitus (Ordered 8/20/20)
3. Metformin HCL Extended Release give 500 mg by mouth one (1) time a day related to Type 2 Diabetes Mellitus (Ordered 4/7/20)
4. Insulin Lispro Inject per sliding scale related to Type 2 Diabetes (Ordered 08/20/2020)

Record review of Resident # 8's comprehensive care plan revealed there was no care plan (focus, goals, or interventions) in place for Type 2 Diabetes Mellitus Atrial diagnosis, including medications (Jardiance, Lantus, Metformin, and Insulin) and labs.

Resident #9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 72	{F 657}		

Record review of the Admission Record revealed Resident #9 was originally admitted on 10/16/2020 and re-admitted on 2/11/2021.
Record review of Resident #9's Diagnosis Information included Type 2 Diabetes Mellitus, Essential Hypertension, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Peripheral Vascular Disease, and Cerebral Infarction.

Review of Resident #9's Physician Orders reveal orders for:

1. Amlodipine Besylate Tablet to MG Give 1 tablet by mouth one time a day for Essential Hypertension (Ordered 11/3/20)
2. Losartan Potassium Tablet 50 MG Give 50 mg by mouth in the morning for Hypertension (Ordered 1/15/21)
3. Furosemide Tablet 40 MG Give 1 tablet by mouth in the morning for Hypertension/Edema related to Essential Hypertension (Ordered 1/26/21)

Record review of Resident # 9's comprehensive care plan revealed there was no care plan (focus, goals, or interventions) in place for Hypertension diagnosis, including medications (Amlodipine Besylate, Losartan Potassium, and Furosemide).

Resident #10

Record review of the Admission Record revealed Resident #10 was admitted to the facility on 3/15/2021.

Record review of Resident #10's Diagnosis Information included Alcohol Dependence, Seizures, Stroke, Alcohol Abuse with Withdrawal,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 73	{F 657}		

and Dementia.

Review of Resident #10's Physician orders revealed the following Physician orders:

1. Levetiracetam Solution 100 mg/milliliter (ML) by mouth two times a day related to seizures (Ordered 3/15/21)
2. Clopidogrel Bisulfate Tablet 75 mg by mouth one (1) time a day related to cerebral infarction, unspecified (Ordered 03/01/2021)

Record review of Resident # 10's comprehensive care plan revealed there was no care plan (focus, goals, or interventions) in place for Seizure Disorder diagnosis, including medications (Levetiracetam Solution) and labs. Also, there is no care plan in place for cerebral infarction diagnosis, including medications (Clopidogrel Bisulfate) and labs.

Resident #11

Record review of the Admission Record revealed Resident #11 was admitted to the facility on 12/15/2018.

Record review of Resident #11's Diagnosis Information included Type 2 Diabetes Mellitus, Seizures, Chronic Pancreatitis, Essential Hypertension, Vitamin B12 Deficiency Anemia, Recurrent Depressive Disorders, Bipolar Type Schizoaffective Disorder, and Chronic Obstructive Pulmonary Disorder.

Record Review of the Physician orders revealed that Resident #11 had the following Physician Orders:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 74	{F 657}		

1. Creon Delayed Release two (2) capsules by mouth before meals for Chronic Pancreatitis (Ordered 9/15/20)
2. Divalproex Sodium Delayed Release 500 mg by mouth two (2) times a day for convulsive disorder (Ordered 12/15/18)
3. Metformin HCL 1000 mg by mouth two (2) days a day for Diabetes (Ordered 12/17/18)
4. Losartan Potassium Table 25 MG Give one (1) tablet by mouth in the morning related to Essential (Primary) Hypertension.

Record review of Resident # 11's comprehensive care plan revealed there was no care plan (focus, goals, or interventions) in place for Diabetes Mellites diagnosis, including medications (Metformin) and labs. Also, there are no care plans in place for Chronic Pancreatitis diagnosis, including medications (Creon Delayed Release). There are no care plans in place for convulsive disorder diagnosis, including medications (Divalproex Sodium) and labs. Also, there is no care plan in place for Hypertension diagnosis, including medications (Losartan Potassium).

Resident #12

Record review of the Admission Record revealed Resident #12 was initially admitted to the facility on 10/24/2020 and readmitted on 1/6/2021.

Record review of Resident #12's Diagnosis Information included Unspecified Atrial Fibrillation, Peripheral Vascular Disease, Chronic Embolism and Thrombosis of Unspecified Deep Veins of Unspecified Lower Extremity, Chronic Kidney Disease, and Essential Hypertension.

Record review of Resident #12's Physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 75	{F 657}		

Orders revealed that the physician ordered the following medications:

1. Apixaban 5 mg by mouth two times a day for Deep Vein Thrombosis (Ordered 1/14/21)

Resident #12 was found unresponsive on May 17, 2021. Resident #12 expired at the facility.

Record review of Resident # 12's comprehensive care plan revealed a care plan focus for the resident that states the resident has altered cardiovascular status r/t arrhythmia (A-Fib) and implanted pacemaker device (Medtronic). There are no interventions in place for medications (Apixaban) and labs.

On 5/6/21 at 2:55 PM, the SA observed the DON do a full body audit on Resident #12. The last weekly wound assessment given by the DON done on 5/3/21 with only a wound to left anterior kneecap noted. The full body audit with the DON revealed one ulcer to both anterior knees and left lower lateral leg above the ankle. The right anterior knee wound had scant amount serous drainage, no odor, and red granulation tissue noted. The left anterior knee wound had moderate amount of serous drainage, no odor, and red/pink granulation tissue. The ulcer to left lateral lower leg had no drainage, no odor, and pink granulation tissue. An assessment of the buttocks revealed three (3) open areas to right buttock and one (1) open area to left buttock. All the three (3) open pressure areas to the right buttock and the one (1) pressure area to the left buttock had minimal bloody drainage and no odor with red granulation tissue noted.

Record review of Resident #12's care plans

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 76	{F 657}		

revealed a start date of 04/14/2021 resident has a Stage 2 ulcer of the heel with interventions to assess/record/monitor wound healing two times weekly measure length, width, and depth. Records review of Physician Orders and wound reports reveal no wound to Resident #12's heels. Resident #12 never had a wound documented to his heels. Record review of Resident #12's care plans revealed no care plans for resident's actual wounds.

On 5/13/21 at 9:30 AM, in an interview with Wound Care Clinic Nurse, RN #2, she explained Resident #12 was seen at the wound care clinic before he went into the nursing facility. She reported he was being treated for venous ulcers to both lower extremities prior to resident being admitted to the nursing facility. She explained Resident #12 was readmitted to the wound care clinic on 12/21/2020 from the facility. She reported Resident #12 was treated on 01/07/2021 for a pressure ulcer to right buttock which was acquired at the facility and the resident had reported to her the wound had been there for about t

Resident #15

Record review of the Admission Record revealed Resident #15 was admitted to the facility on 11/25/2020.
Record review of Resident #15's Diagnosis Information included Chronic Pain Syndrome, Type 2 Diabetes Mellitus, Essential Hypertension, and Hypertensive Heart Disease.

Review of Resident #15's Physician Orders revealed Physician Order includes Basaglar

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 77	{F 657}		

Kwikpen Solution 100 unit/ml Inject 15 units subcutaneously one (1) time daily for diabetes.

Record review of Resident # 15's comprehensive care plan revealed there was no care plan (focus, goals, or interventions) in place for Diabetes Mellites diagnosis, including medications (Basaglar) and labs.

Resident #16

Record review the Admission Record reveals Resident #16 was admitted to the facility on 2/26/21 and readmitted to the facility on 4/16/21.

Record review of Resident #16's Diagnosis Information include Schizophrenia, Seizures, Essential Hypertension, and Cellulitis of Left Lower Limb.

Record Review of the Physician orders reveals that Resident #16 had the following Physician Orders:

1. Amlodipine Besylate 10 MG give 1 tablet by mouth one time a day related to Essential Hypertension
2. Lisinopril 10 MG give 1 tablet by mouth one time day related to Essential Hypertension (Ordered 2/26/21)
3. Levetiracetam 250 MG give 1 tablet by mouth one time a day related Seizures (Ordered 2/26/21)
4. Metoprolol Tartrate 50 MG give 1 tablet by mouth two times a day related to Essential Hypertension (Ordered 2/26/21)
5. Divalproex Sodium Tablet Delayed Release 500 MG Give 1 tablet by mouth one time a day related to Seizures (Ordered 4/17/21)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 78	{F 657}		

Record review of Resident # 16's comprehensive care plan revealed there was no care plan (focus, goals, or interventions) in place for Hypertension diagnosis, including medications (Amlodipine Besylate, Lisinopril, and Metoprolol Tartrate). Also, there is no care plan in place for seizure diagnosis, including medications (Divalproex Sodium and Levetiracetam) and labs.

Resident #17

Record review the Admission Record revealed Resident #17 was originally admitted to the facility on 3/4/2021 and readmitted on 3/10/2021.

Record review of Resident #17's Diagnosis Information revealed, Osteomyelitis of Vertebra, Sacral and Sacrococcygeal Region, Unstageable Pressure Ulcer of Sacral Region, Gram Negative Sepsis, Congestive Heart Failure, Atherosclerotic Heart Disease, Diabetes Mellitus due to Underlying Condition with Foot Ulcer, Chronic Obstructive Pulmonary Disease, Chronic Peripheral Venous Insufficiency and Essential Hypertension.

Record Review of Resident #17's Physician Orders revealed the following Physician Orders:

1. Metoprolol Tartrate Tablet 25 MG Give 1 tablet by mouth two times a day related to Essential Hypertension (3/4/21)
2. Furosemide Tablet 40 MG Give 1 tablet by mouth one time a day related to Congestive Heart Failure (Ordered 3/5/21)
3. Isosorbide Mononitrate ER Tablet 60 MG Give 1 tablet by mouth one time a day related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 79 Atherosclerotic Heart Disease (Ordered 3/4/21) Record review of Resident # 17's comprehensive care plan revealed there was no care plan (focus, goals, or interventions) in place for Hypertension diagnosis, including medications (Isosorbide Mononitrate and Metoprolol Tartrate). Also, there is no care plan in place for Congestive Heart Failure, including medications (Furosemide). On 05/05/2021 at 10:45 AM, in an interview with CNA #7, he explained he has been a CNA and worked at the facility for two years. When ask CNA #7 regarding how he knows the care each resident requires he explained that you can look at the computer at the Resident's plan of care and ask the nurse. He further explained sometimes he does rounds with the off going CNA and get an update on each resident but sometimes the CNAs are already gone. On 5/6/21 at 9:45AM, in an interview with CNA #6, she explained she has been a CNA for 11 years, and 1 year at the facility. When ask how she is aware of individual resident's needs, she explained look the care plans on the computer. She reported the CNAs used to have pocket guides but now everything is on the computer. When ask if she noticed a change in a resident what would she do, she explained she would notify the Resident's nurse, ADON and DON. On 5/7/2021 at3:15 PM, in an interview with Registered Nurse (RN) #1, she said she is responsible for updating the care plans. The nurse said If the resident has a decline with transfers, the CNA notifies the nurse, the nurse notifies therapy and therapy gives her their recommendations. All lifts are place on the	{F 657}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 80	{F 657}		

resident's care plans. RN #1 said she did not know what else do with Resident #1. The local Behavioral health did not give recommendations except for the medication. RN #1 said the DON and Administrator said the facility did not have enough staff to do a one on one. RN #1 revealed she has not had Behavioral health training. RN #1 said all residents are assess for transfers. Sometimes the staff transfer the residents with lifts without recommendations from Therapy or without it being on the care plan. This is not the facility policy. The nurse confirmed Resident #1's care plan was not updated after his stay at the Behavioral facility. RN #1 said she thought it was updated but realized she had not done it when the SA came into the building. RN #1 said it is her responsibility to update the care plans and to provide interventions along with the nursing departments help. RN #1 said she has started updating the care plans daily by printing off all new orders and placing them on the care plan. RN #1 also said all high-risk medications should be added to the care plan. RN #1 confirmed she does not have any behavioral health training.

On 5/13/21 at 11:00 AM, in an interview with the Minimum Data Set (MDS) nurse, RN #1, she explained since she took over the MDS job she has been trying to update all care plans as Resident concerns come up. She explained the DON and her are the nurses who mostly do the care plans, but she has noticed that some of the nurses on night shift has tried to update care plans as needed.

On 05/13/21 at 11:30 AM, in an interview with LPN #5, she explained she does not do any updates on the care plans for residents. She further explained she thought the DON and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 81	{F 657}		

MDS nurse was responsible for resident's care plans.

On 05/13/2021 at 1:30 PM, in an interview with the DON, she explained she did work in MDS prior to becoming DON and did care plans as the MDS nurse. She explained since becoming the DON, she has not been able to keep up with the Resident's care plans as she should. She further explained she is still learning all the roles of the DON and trying to learn as she goes. She reported prior to becoming DON, she worked in the MDS department and tried to update care plans frequently but reported during COVID-19 and lately she has had to work the medication carts and not be able to do her jobs. When asked what the purpose of the Resident's care plan, she explained the care plans are to ensure that the resident is taken care of the right way. When asked if a care plan is not updated could that cause any problems for the resident, she explained "yes", the resident may not get all the care they require and could cause accidents.

Removal Plan:
On 5/23/21, the Charge Nurses, MDS Coordinator, and DON were in-serviced regarding a failure to assess wounds weekly, and immediately update or develop care plans when wounds change.
Residents #4, #8, #9, #10, #11, #15, & #16's Care Plans were assessed and updated with correct staging, treatment and interventions and Therapeutic medications. in addition:
Resident #1's behavior assessment was completed on 5/5/21 and a behavior health care plan was completed indicating that the incident occurred on 5/4/21.
Resident #2 Care Plan was reviewed for use of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 657}	Continued From page 82	{F 657}		

mechanical lift by the MDS Coordinator on 5/5/21; no changes needed. CNA#3 did not follow Care Plan. On 5/21/21, the care plan was reviewed and revised.
On 5/27/21, CNA #3 was removed from PRN list and later terminated because he/she did not follow policy and/or Resident's care plan resulting in Resident's injury.
Resident #3's Care plan was updated by the MDS Coordinator and Certified Wound Care Nurse to include the wound care clinic appointments, correct staging, and current wound care orders for sacrum wound on 5/18/21.
Resident #5 was discharged on 1/21/21. No care plan to update due to discharge.
Resident #6 On 5/18/21, the MDS Coordinator correct the MDS dated 12/8/20 no wounds were in Section M.
MDS Coordinator updated care plan for wounds on 5/21/21.
Certified Wound Care Nurse assessed Resident for wounds on 5/23/21; no care plan revisions required after assessment.
Resident #7 The MDS Coordinator reviewed MDS dated 4/18/21. No MDS correction was allowed as the documentation supplied with updated information on wounds was supplied outside of the
allowed look back period to use for the MDS assessment per the RAI manual. o Certified Wound Care Nurse assessed Resident #7 on 5/22/21.
On 5/24/21, MDS Coordinator updated the care plan with correct number of wounds and treatment.
Resident #12
Discharged on 5/17/21. No revisions to Section M of the 4/16/21 MDS are needed as the additional wounds noted occurred and were documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 83	{F 657}		

after the allowed assessment period per the RAI manual.
Resident #13- Certified Wound Care Nurse assessed Resident #13 on 5/22/21. MDS Coordinator updated the care plan on 5/25/21.
Resident # 14 - DON completed an assessment of Resident #14's wounds on 5/27/21. The MDS Coordinator updated the care plan on 5/28/21 after Resident returned from a hospital stay spanning 5/20/21 to 5/27/21 to include the treatment and intervention to the Stage 2 on the Buttocks.
Resident # 17's - Certified Wound Care Nurse assessed the wound on 5/22/21 and MDS Coordinator updated the Care plan on 5/24/21 to include the correct staging of the wound on left heel and therapeutic medications.
On 6/03/21 Corporate Management approved for Wound Care Specialists from other facilities to work in the facility to assist with audits of wounds, wound care, training, and assist with correcting care plans.
On 5/6/21, the ADON, MDS Coordinator, and Regional Nurse reviewed all other Resident's care plan for complete and accurate information for behaviors, skin issues and therapeutic medications. Care plans were updated for residents for whom their care plans were not accurate.
The Care Plan Committee implemented comprehensive care plans for Residents #2, 3, 6, 7, 9, 10, 11, 14, 15, 17, 20, 30, and 31 on 5/21/2021 related to lifts, wounds, and medications. Residents # 4, 5, 12, and 16 are discharged so changes to the care plan could not be made.
Validation:
The State Survey Agency (SA) validated through review of sign-in sheets and interviews with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 657}	Continued From page 84	{F 657}		

licensed nurses the Nurse Consultant conducted in-services for charge nurses, the MDS Coordinator, and the Director of Nursing (DON) regarding assessing wounds weekly and immediately updating and/or developing care plans based on the weekly wound assessments.
The SA validated through review of Comprehensive Care Plans and an interview with the MDS Coordinator Residents #4, #8, #9, #10, #11, #15, & #16 care plans were reviewed and updated with correct staging, treatment, and interventions.
The SA validated through record review a behavior assessment was completed by the Psychiatric Nurse Practitioner and the care plan was revised for Resident #1.
The SA validated through record review and interview with the MDS Coordinator the care plan for Resident #2 was reviewed and revised to include use of mechanical lift.
The SA validated through review of CNA termination report and interviews CNA #3 was terminated.
The SA validated through record review and interviews the Comprehensive Care Plan for Resident #3 was updated to include the wound care clinic appointments, correct staging and current wound care orders for sacrum wound by the MDS Coordinator and Wound Care Nurse Specialist.
The SA validated through record review and interview Resident #5 was discharged from the facility on 1/21/21.
The SA validated through review of the Comprehensive Care plan and Weekly Wound Report and interviews with the MDS Coordinator and the Certified Wound Care Nurse, Resident #6's care plan was revised to include wounds.
The Certified Wound Care Nurse verified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

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LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 657}	Continued From page 85	{F 657}		

completion of a wound assessment for Resident #6.
The SA validated through review of the Comprehensive Care Plan and Weekly Wound Report and interviews with the MDS Coordinator and the Certified Wound Care Nurse, Resident #7's care plan was revised to include wounds and treatment. The Certified Wound Care Nurse verified completion of a wound assessment for Resident #7.
The SA validated through review of the Comprehensive Care Plan and interviews with the MDS Coordinator, Residents #8, #9, #10, #11 care plans were revised to include therapeutic medications.
The SA validated through record review of the Pressure Wound Assessment, the Comprehensive Care Plan, and interviews with the Certified Wound Care Nurse and the MDS Coordinator, Resident #13 was assessed for wounds and the MDS Coordinator updated the care plan to include wounds.
The SA validated through record review of the Pressure Wound Assessment, the Comprehensive Care Plan, and interviews with the
Wound Care Nurse Specialist and MDS Coordinator, Resident #14 was assessed for wounds and the MDS Coordinator updated the care plan to include the treatment and intervention to the Stage 2 on the Buttocks.
The SA validated through record review of the Pressure Wound Assessment, the Comprehensive Care Plan, and interviews with the Certified Wound Care Nurse and the MDS Coordinator, Resident #17 was assessed for wounds and the MDS Coordinator updated the care plan to include the correct staging of the wound on the left heel.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 657}	Continued From page 86 The SA validated through interview with Senior Director of Operations and current wound care specialist for other facility that Corporate Management approved for Wound Care Specialist from other facilities to work in the facility to assist with audits of wounds, wound care, training, and assist with correcting care plans. The SA validated through review of an audit form completed by the ADON, MDS Coordinator, and Regional Nurse all Residents care plans were reviewed for accuracy and care plan information was updated to include Behaviors, Skin issues, and therapeutic medications for residents as needed. Results of the audit include updates to Residents #9, #10, #11, #15, #20, #30, and #31 care plan related to lifts, wounds, and medications. The SA validated through record review and interview Residents #4, #5, #12, and #16 was discharged	{F 657}		
{F 686} SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	{F 686}		7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 87 This REQUIREMENT is not met as evidenced by: Based on observations of staff and residents, staff and resident interviews, record review, and facility policy review, the facility failed to ensure residents received care, consistent to prevent pressure ulcers, to promote the healing of pressure ulcers, prevent an infection, and prevent new ulcers from developing for eight (8) of nine (9) residents sampled. Residents #3, #5, #6, #7, #12, #13, #14, and #17. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 04/06/2021 when the facility failed to ensure Resident #7's wound was free from infection as evidenced by the wound developed a foul odor and increased drainage. This wound was cultured and revealed an infection present in the wound bed. The facility's failure to ensure residents received care, consistent to prevent pressure ulcers, to promote the healing of pressure ulcers, prevent an infection, and prevent new ulcers from developing placed the residents in a situation that caused or is likely to cause serious harm, injury, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) on 05/05/2021 and was determined to exist on 04/06/2021. The IJ was not removed prior to exit on 05/26/2021 and is considered ongoing. The IJ and Substandard Quality of Care (SQC) existed at CFR(S): 483.25(b)(1)(i)(ii)-Treatments/Services to Prevent/Heal Pressure Ulcer	{F 686}	1. The Certified Wound Care Nurse and MDS Coordinator assessed wounds for staging and treatment on 5/28/21 for Residents #3, #5, 6#, #7, #12, #13, #14, and #17 to ensure correct treatments are being provided and interventions are appropriate for the wounds identified. Any necessary changes to treatment and medications were reported to the Medical Director on 5/28/21. Any physicians orders were entered at that time and the care plans updated. Resident #3s Care plan was updated by the Minimum Data Set Coordinator and Certified Wound Care Nurse. Residents #5 was discharged on 1/21/21. Resident #6s MDS care plan was updated on 5/21/21. In addition, the Certified Wound Care Nurse assessed the resident for wounds on 5/23/21; no care plan revisions were required after assessment. Resident #7 The MDS Coordinator reviewed the MDS dated 4/18/21. No MDS correction was allowed as the documentation supplied with updated information on wounds was supplied outside of the allowed look back period to use for the MDS assessment per the RAI manual. A Certified Wound Care Nurse assessed Resident #7 on 5/22/21, and on 5/24/21. The MDS Coordinator updated the care plan. Resident #12 Resident was discharged on 5/17/21. No revisions to Section M of the 4/16/21 MDS are necessary as the additional wounds noted occurred and were documented after the allowed assessment period per the RAI manual.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 88 The IJ was not removed prior to the State Agency (SA) exit on 5/26/2021 and was considered ongoing. The facility provided a Credible Removal Plan of IJ, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit in order to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interview, record review, and in-service review. The facility provided evidence the facility had implemented corrective actions listed in the Credible Allegation of Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for 42 CFR 483.25(b)(1)(i)(ii) has been lowered from the scope and severity of a "K" to the scope and severity of an "E". The facility will remain out of compliance at Scope and Severity of "E" that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: The facility's, "Skin Care Process" policy, revealed a date of January 17, 2018. "It is the policy of this facility to provide care and services with the goal of maintaining the resident's skin integrity and to provide care and services that	{F 686}	Resident #13- A Certified Wound Care Nurse assessed Resident #13 on 5/22/21. The MDS Coordinator updated the care plan on 5/25/21. Resident # 14 □ The DON completed an assessment of Resident #14□s wounds on 5/27/21. The MDS Coordinator updated the care plan on 5/28/21 after the resident returned from a hospital stay spanning 5/20/21 to 5/27/21. Resident # 17□s □ A Certified Wound Care Nurse assessed the wound on 5/22/21 and the MDS Coordinator updated the care plan on 5/24/21. On 6/03/21, Corporate Management approved for Wound Care Specialists from other facilities to work in the Facility to assist with audits of wounds, wound care, training, and assist with correcting care plans. The Wound Care Specialist began on 6/3/21. All Residents listed have been thoroughly assessed & reassessed regarding the wound care provided to them in the Facility. Care plans have been updated, and education has been provided to all staff regarding: measurements, Braden scale frequency, notification of families about new wounds and status of wounds, and documentation of care provided. The Care Plan Committee implemented comprehensive care plans for Residents #2, 3, 6, 7, 9, 10, 11, 14, 15, 17, 20, 30, and 31 on 5/21/2021 related to wounds and medications. Resident # 4 discharged on 1/29/20, Resident 5 discharged on 1/21/21, and Resident #12 discharged on 5/17/21. The wound care-certified Regional Nurse Consultant educated the Director of Nursing regarding the skin and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 89 meet professional standards to treat the loss of skin integrity should it occur ...Process: The skin care process has 6 components: 1. Evaluation of the resident's skin condition 2. Determining risk for altered skin integrity. 3. Developing and implementing an individualized plan of care. 4. Evaluating the effectiveness of the plan of care and revising approaches as needed. 5. QAPI system for overall effectiveness of the skin care process. 6. Staff education related to the skin care process. Process Guidelines: 1. Evaluation of the resident's skin condition on admission as as needed. 2. Determining the risk for altered skin integrity: a. The Admit/Readmit Physical Evaluation should be completed on admission and readmission. b. The Braden Scale should be completed upon admission, readmission, quarterly and as needed to determine pressure ulcer risk. c. The Malnutrition Risk Assessment should be completed on admission, readmission, quarterly and as needed. 3. See care plan process. 4. If a wound is not showing signs of improvement within 2 weeks of treatment, a re-evaluation of the wound and change in treatment should be considered. 5. QAPI system for evaluating the overall effectiveness of the skin care process. 6. Staff education: Nursing staff should receive training regarding skin and skin care as appropriate upon hire and periodically thereafter. Nurses may need further training in evaluation, assessment, staging and measuring wounds prior to being responsible for wound care ... Pressure Wounds: The goal of this facility in regard to pressure wounds is to promote the prevention of the healing of pressure wounds that are present and to minimize the potential for development of new pressure wounds using the Skin Care Process."	{F 686}	wound care process including prevention, identification, treatment, documentation, wound vacs, and tracking and reporting wounds on 5/23/2021. 2. All residents with skin integrity concerns have the potential to be affected by the deficit practice cited. 3. The Regional Nurse Consultant contacted American Medical Technologies (AMT) to request an in-service for nursing staff related to skin and wounds on 5/21/21. AMT completed an evaluation of Facility residents wounds on 6/4/2021 for any necessary additional changes. The Nurse Practitioner was scheduled to attend a training and education with AMT on 6/4/21 to gain knowledge regarding assessing and staging wounds and the clarification of appropriate wound treatment orders however she refused to attend the training. The Assistant Director of Nursing completed skills competencies with the Regional Nurse Consultant on 5/21/2021 that included routine competencies, skin and wound, behavioral health, and medication administration. On 5/22/21, the Charge Nurses, MDS Coordinator, and Director of Nursing were provided an in-service to educate them regarding the failure to assess and document wounds weekly and to change, develop, or update the resident s care plan immediately when wounds change. Beginning 5/6/21, all other residents care plans were evaluated for behaviors and wounds, and a comprehensive plan of care was completed for each resident. CNA competency training--including toileting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 90 Resident #3 On 05/05/21 at 1:15 PM in an observation of wound care on Resident #3 with Licensed Practical Nurse (LPN) #5 revealed the nurse cleansed a large, opened wound to sacrum with wound cleanser, there were no odors are drainage. The wound bed is pink with maceration around the edges. The nurse cleansed with wound cleanser and packed with Santyl, gauze, covered with dry dressing. On 05/06/21 at 1:15 PM in an interview with the Resident #3's daughter revealed Resident #3 acquired the wound in the facility. The daughter said she hired a sitter several months ago to assist the resident because the staff was not turning her and assisting with meals. 0n 5/05/21 at 1:30 PM interview with LPN #5, said explained Resident #3 acquired the wound in the facility. She further explained Resident #3 acquired the wound before she started working at the facility. She reported she does the treatments, but she does not measure the wounds and the DON is responsible for keeping up with the measurements. Record review of Resident #3's Weekly Pressure Injury record dated 09/30/2020, revealed the Stage 3 wound to the sacrum measured 1 centimeter (cm) x 4.0 cm x 0.5 cm with granulation tissue. The next Weekly Pressure Injury Record was dated 1/11/2021 and was blank with no information entered. The most recent weekly Pressure Injury Record was completed on 5/07/2021 and revealed Resident #3 had a Stage 3 pressure ulcer to the sacrum measuring length	{F 686}	techniques, turning, and positioning were completed by 6/1/21 by the Lead CNA. On 5/22/21, the Regional Nurse Consultant conducted education for the Director of Nursing, Assistant Director of Nursing/Infection Control Coordinator, and Medical Records Nurse regarding monitoring care plans, medication administration, wound care treatments and documentation, pharmacy services, and communication with Governing Body. Licensed nursing staff completed body audits on all patients on 5/23/2021, any new skin concerns were addressed at that time. The Regional Nurse Consultant and ADON/ICC began on 5/27/21 and completed on 5/29/21 a review of all residents□ care plans for skin issues, therapeutic medications on their care plans, and any behaviors noted to ensure that the care plans are current and up to date. No RD recommendations were made. Treatment Administration Records are reviewed by the IDT daily in clinical stand up meetings to monitor for omissions. 4. The Director of Nursing or ADON will review the wound care log weekly times four weeks beginning 7/1/21 and then monthly beginning 8/2/21 times three months. Residents identified with wounds will be discussed during the weekly Persons At Risk meeting beginning the week of 7/1/21. Findings will be brought to Quality Assurance Performance Improvement monthly beginning 7/2/21 for review, revision, or resolution of the plan for six months. Independent monitoring began 6/7/21 by an outside consulting firm	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 91 4 cm, width 5 cm, depth 0.75 cm and tunneling of 2 cm at 6 o'clock and a Stage 2 pressure wound to the right gluteal fold measuring 1 cm X 1.5 cm X 0.1 cm. Record review of Resident #3's first 03/04/2021 with Wound Care revealed measurement for sacrum Stage 3 pressure injury length 6.0 cm, width 5.0 cm, and depth 0.6 cm. The report revealed large amount of serosanguineous exudate with no tunneling, but wound did have slough noted. On 5-13-21 at 9:30 AM, in an interview with (Proper Name) Wound Clinic Wound Care Nurse, Registered Nurse (RN) #2, she explained the facility has three (3) residents that come for wound care. She explained the residents come once every three (3) weeks and the facility does a rotation schedule for the three (3) residents. When asked regarding Resident #3, she explained the resident was referred to wound care on 03-04-21 for a stage 3 decubitus ulcer. She further explained that was all the Resident #3's referral said. She explained she has no start date of the decubitus and not sure exactly when the wound began. She reported Resident #3 was seen years ago for the same wound but in August 2017 the facility stopped sending residents due to the facility wanted to do the wounds in house. Record review for Resident #3's Face Sheet revealed the facility initially admitted Resident #3 on 02/24/2019 with the diagnoses of Atrial Fibrillation, Type 2 Diabetes Mellitus, Pressure Ulcer Sacral Region Stage 3, Hemiplegia and Hemiparesis, Peripheral Vascular Disease, Cardiomegaly, and High Blood Pressure. Record review Quarterly Minimum Data Set with	{F 686}	is being performed for compliance assistance. The Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 92	{F 686}		

Assessment Reference Date (ARD) dated for 2/15/21 Section C revealed Resident #3 had a Brief Interview of Mental Status (BIMS) score of 05, which indicates severe cognitive impaired. Section G revealed Resident # 3 required two (2) plus person assistance with bed mobility and transfers. Section H revealed Resident #3 was always incontinent of bowel and bladder. Section M revealed Resident #3 had a Stage 3 pressure ulcer.

Record review of Dietician Progress notes revealed Resident #3 has been seen monthly since 12/16/2020. The progress notes revealed Resident #3 was seen 4/28/2021 regarding wound review and hospital return with a weight gain of 6.4 percent (%) in the past 30 days with supplements Boost three times a day, Juven twice a day, and Promod twice a day.

Record Review of Resident #3 Physician Orders revealed wound care order dated for 03/15/2021 and end date of 04/09/2021 states to cleanse sacral decubitus wound with wound cleanser twice daily, apply Santyl to wound bed and cover with large foam border dressing, daily and additionally if dressing becomes soiled. A physician order dated 03/16/2021 states for resident to have a wound care appointment at the (Proper Name) wound clinic every two (2) weeks. A Physician Order dated 04/09/2021 states to cleanse sacral decubitus wound with wound cleanser daily, apply Santyl to wound bed and cover with large foam border dressing. The Physician Orders also included a wound care order dated 04/20/2020 states to cleanse with wound cleanser pat dry apply collagen pad (puracol) to fit into the wound bed with calcium alginate silver ribbon cover with a bordered super

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 93	{F 686}		

absorbent dressing daily one time a day and has a discontinued date of 03/17/2021. An additional order dated 10/30/2019 states to visually check dressing to Stage 3 ulcer every shift and the order was discontinued on 03/19/2021.

A record review of Resident #3's last Braden Scale with a date of 09/30/2020 revealed Resident # 3 is moderate risk for pressure ulcer with a score of 13.

Record review of Nursing Progress Notes revealed a Patient at Risk (PAR) dated for 3/12/2021 with a care plan meeting with Resident #3's daughter and concerns regarding Resident #3's care. The noted revealed a staff member will go with resident to wound care, frequent visual observations to ensure wound care being carried out, and having nurse initial, date, and time the bandages were changed. The note revealed no measurements of the wound. The record revealed the previous PAR note was dated for 07/22/2020 with Stage 3 sacral area measurements 2.5 cm x 2 cm x 0.3 cm with bright pink granulation tissue with white edges related to maceration with no odor and scant amount of serous drainage.

Record review of Nursing Progress Notes revealed a Patient at Risk (PAR) note dated for 3/12/2021 with a care plan meeting with Resident #3's daughter and concerns regarding Resident #3's care. The noted revealed a staff member will go with resident to wound care, frequent visual observations to ensure wound care being carried out, and having nurse initial, date, and time the bandages were changed.

Record review of Resident #3's Treatment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 94	{F 686}		

Administration Record (TAR) for January 2021 revealed omitted documentation for the treatment of Stage 3 ulceration to sacrum on 1/1/21, 1/2/21, 1/8/21, 1/9/21, 1/10/21, 1/15/21, and 1/16/21 for a total of seven (7) entries omitted in January. Record review of the TAR for March 2021 revealed omitted documentation for the treatment of sacral wound on 3/9/21, 3/11/21, 3/15/21, 3/22/21, 3/27/21, and 3/28/21 for a total of six (6) entries omitted in March. Review of April 2021 TAR revealed omitted documentation for the treatment of sacral wound on 4/2/21, 4/3/21, and 4/7/21 for a total of three (3) entries omitted in April.

A record review of lab results for Resident #3 revealed Albumin level low at 1.9 dated for 03/24/2021.

Resident #5

SA phoned son of Resident #5 on 05/04/21 at 11:00 AM. SA asked him regarding his mom's care while a resident at Liberty Nursing Home, and he explained the first concern was his mother got bedsores while at the facility.
Record review of Resident #5's Admission Record revealed the facility admitted Resident on 05/19/2020 with the diagnoses of Hypothyroidism, Major Depressive Disorder, Anorexia, Heart Failure, History of Transient Ischemic Attach (TIA) and Cerebral Infarction without Residual Deficits, High Blood Pressure, Chronic Kidney Disease, Type 2 Diabetes, Unspecified Urethral Stricture, female, Pressure Ulcer of right buttock Stage 2, and Pressure ulcer of left heel, unstageable, which indicated the pressure ulcers to right buttock and left heel were present on admission. Resident #5 was discharged to another facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 95 1/21/2020. Record review of Resident #5's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of November 16, 2020, Section C revealed Resident #5 had a BIMS score of 06, which indicated Resident #5 had severe cognitive impairment. Section G of the MDS revealed Resident #5 required extensive assistance with two plus persons. Section H of the MDS revealed Resident #5 had an indwelling catheter and always incontinent of bowel. Section M of the MDS revealed Resident #5 had one (1) Stage 2 and one (1) unstageable wound. The latest Discharge MDS with ARD of 1/21/2021 revealed the same findings as the quarterly MDS. Record review of Resident #5's Initial Weekly Wound Pressure report dated 05/20/2020 revealed resident #5 was admitted with a wound on the left heel, inner aspect, unstageable, with measurements of 2 cm x 1.4 cm x 0.2 cm and wound to right buttock Stage two with measurements 1 cm x 1 cm x 0.2 cm. Review of Resident #5's Nurse Progress Notes dated 05/25/2020 revealed a new area to left gluteal fold with partial thickness measurements of 1.5 cm x 0.5 cm x0.1 cm with cleansed area with wound cleanser pat dry, zinc oxide applied to area. There was no weekly body audit with the new wound to left gluteal fold with measurements. Review of Resident #5's weekly body audit dated 06/17/2020 revealed no measurements and continue treatment to coccyx and right foot. Further record review of Resident #5's weekly body audits dated 09/02/20, 09/28/20, 10/14/20 revealed body audits with wounds right and left buttock with no measurements recorded.	{F 686}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 96	{F 686}		

Record review of Physician Progress note for dated 05/27/2020 revealed Resident #5 had large left heel decubitus Stage 4.

Record review of Resident #5's Physician Orders dated for 05/20/2020 revealed orders for heel protectors at all times, an air floatation mattress for pressure reduction related to Stage 2 to right buttock, an order for Stage 2 to right buttock cleanse with wound cleanser and pat dry apply hydrogel to wound bed only and cover with silicone border foam dressing daily, and unstageable ulceration to left heel (inner aspect) to cleanse with wound cleanser, pat dry, apply Santly to wound bed only, cover with 4x4, abdomen pad, and wrap with Kerlex and secure with tape daily. A new order dated 06/12/2020 for denuded area to left buttock cleanse area with wound cleanser and pat dry apply zinc oxide cover area with silicone dressing daily and Stage 2 to right buttock to cleanse with wound cleanser and pat dry, apply zinc oxide 20% to area and cover with silicone dressing daily. A new order dated for 08/03/2020 states unstageable ulceration to left heel (inner aspect) cleanse with wound cleanser and pat dry, apply sure prep to wound bed only, cover with 4x4 and foam heel dressing and wrap with Kerlex and secure with tape every two days.

Record review of Resident #5's only lab value record dated 06/03/2020 with an Albumin level 2.8, which indicated a low level.

Record review of Resident #5's only Braden Scale dated 09/30/2020 for predicting pressure sores revealed Resident #5 is at high risk for developing pressure sores.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 97	{F 686}		

Record review of Resident #5's Treatment Administration Record (TAR) revealed when resident first arrived at the facility in May 2020, Resident #5 had missing documentation for treatment to left heel were missed on 05/21/2020, 05/22/2020, 05/23/2020, 05/27/2020, 05/28/2020, and 05/29/2020 and missing documentation for treatment to Stage 2 to right buttock on 05/21/2020, 05/22/2020, 05/27/2020, 05/28/2020, and 05/29/2020.

On 5/5/2021 at 3:00 PM, in an interview with the DON, when asked if a treatment is not initialed what does that mean, she reported if it is not documented than it is not done. She further explained the treatments on the Treatment Administration Record should be initialed after the treatment is done.

Resident #6

Interview on 5/2/2021 at 11:00 am with Resident #6's daughter revealed her mother is not cognitively impaired. She reported her mother developed a sore on her ankle while at the facility and still has the sore. She reported the staff does not do the treatments regularly.

Observation and interview on 5/6/21 at 3:30 PM, revealed LPN #10 performed a skin assessment on Resident #6. LPN #10 explained Resident#6 has had the wounds for a long time and reports the wound will get better and then open back up. No dressing observed to wounds. Observed LPN #10 measure wounds with a paper ruler for each wound, wounds measurements were documented by LPN #10 to be left ankle 1.5 cm x 1.0 cm and right ankle measurement 1.5 cm x 1.5 cm x 0.2 cm. Both wounds to ankle were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 98	{F 686}		

covered with blue dye, wound tissue dyed blue with some darker tissue to the center of the wounds, and wounds edges both irregular. The wounds had no drainage.

Record review of Resident #6's weekly body audit dated for 01/08/2021 only reports no new skin alterations. Body audits dated 03/02/2021, 04/27/2021, 05/06/2021 revealed no measurements of wound to ankles and no weekly pressure injury records available. A weekly body audit dated 03/03/2021 revealed right and left ankles with both wounds measuring 1.0 cm x 1.0 cm with callous like wound on ankles. Three weekly skin reports provided by the DON revealed on 01/28/2021 Resident #5 had bilateral ankle abrasions with one measurement of 2.0 cm x 2.0 cm; on 03/15/2021 resident had non-pressure wounds to bilateral ankles, the wounds were facility acquired and a measurement of 2.0 cm x 2.0 cm one set of measurements for bilateral ankles; and on 04/13/2021 facility acquired non-pressure wounds to bilateral outer ankles and a measurement of 1.5 cm x 1.5 cm. A Pressure Report dated 05/08/2021 revealed Resident # 6 with pressure wounds to bilateral ankles with measurements left ankle 1.5 cm x 1.2 cm and right ankle 1.5 cm x 1.5 cm with Stage 2 noted with eschar tissue per DON skin assessment.
05-10-21 at 3:45 PM In an interview with Resident #6 she explained she got the wounds to her ankles years ago and at first the facility did not do anything about them for a long time. She reported that she keeps hitting her ankles on the wheelchair. She reported the facility does paint the wounds with something blue but still does not do it every day. She explained that the areas still hurt with any pressure on the ankles.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 99	{F 686}		

Record review of Resident #6's Face Sheet revealed the facility initially admitted Resident #6 on 07/31/2017 and readmitted on 01/16/2019 with the diagnoses of Cerebral Infarction, Atrial Fibrillation, High Blood Pressure, and anxiety disorder. The Face Sheet revealed Resident #6 had an added diagnosis of Pressure ulcer Stage 2 to unspecified ankle on 05/07/2021.

Record review of Resident #6's Annual MDS with ARD date 2/26/2021 Section C revealed Resident #6 had a BIMS score of 13, which indicated Resident #6 is cognitively intact. Section M revealed Resident #6 had a Pressure ulcer of 1 or greater or a scar over a bony prominence. Section M had no other areas flagged for skin conditions. Resident #6's Quarterly MDS with ARD date 12/08/2020 Section M had no areas flagged for skin conditions.
Record review of Resident #6's Physician Orders revealed orders for date of 1/21/2021 and discontinued date 03/12/2021 for change duoderm dressings to bilateral ankle abrasions every 3 days, fluff bilateral ankles with 4X4 gauze and ace wrap or wrap with Kerlix, check dressing daily to ensure appropriate coverage of wounds, order for clean bilateral ankles with normal saline or wound cleanser, pat dry, apply skin prep and hydrocolloid dressing change every 3 days with start date of 02/02/2021 and discontinued 03/10/2021; Santyl ointment topically every day shift for wound care, clean bilateral ankles with wound cleanser, pat dry, apply Santyl and wrap with Kerlix daily with start date 03/11/2021 and discontinue date 04/04/2021; inspect resident's feet daily every shift, and Gentian Violet solution apply to outer ankle wounds bilaterally topically one time a day for wound care, cleanse bilateral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 100	{F 686}		

outer ankle wounds with soap and water, pat dry, apply Gentian Violet solutions and wrap with Kerlix start date 04/05/2021.

Record review of Resident #6's only Braden Scale report available dated 06/23/2020 revealed Resident #6 was a low risk for predicting pressure sores.

Record reveal of Resident #6's most recent lab results dated 05/05/2021 revealed an Albumin level of 3.1.

Resident #7

On 05/05/2021 at 7:30 AM, in an interview with LPN #5 during medication administration to Resident #7, the resident received Cipro 500 milligram (mg). When asked LPN #5 why resident was receiving antibiotics, she explained Resident #7 has an infection. When asked what type of infection, LPN #5 explained Resident #7 has a wound infection. She explained she will be doing his wound care later today.

On 5/6/21 at 10:30 AM, during an observation of wound care by LPN #5 for Resident #7's sacral wound and right gluteal fold, the sacral wound was observed with a moderate amount of brown, purulent drainage with a foul odor noted. The wound bed tissue was brown and necrotic with some slough noted to the sacral wound. The right gluteal fold wound had 75 % slough with a scant amount of purulent drainage. LPN #5 explained Resident #7 has had the wound to his sacrum for a long time. She further explained the wound had gotten worse since the resident was in the hospital last month. She reported that he used to go to wound care, but not sure when and no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 101	{F 686}		

longer does. She reported the wound to resident's right gluteal fold was new after his last hospital stay. LPN #5 and SA only observed two (2) open pressure wounds for Resident #7, one to the sacrum and one to the right gluteal fold.

On 05/06/21 at 10:45 AM, in an interview with CNA #7, he explained has been a CNA and at the facility for two years. He reported that the Resident #7 has had the wound to his sacrum for a long time and that it would heal and then be bad again.

On 05/11/21 at 2:20 PM, in an interview with the DON prior to wound measurements on Resident #7, the DON asked the SA if she could just pull-down bandage and measure the resident's wounds. While measuring Resident #7's wound, she explained she does not know where she got only one wound measurement for Resident #7 on 05/08/21. She further explained the area to Resident #7's right gluteal fold is new. While measuring the sacral wound, she reported "the wound stinks."

Observation on 5-11-21 at 2:30 PM, Resident #7 had two bandages intact, one to the sacrum and one to the right hip. The SA observed the DON remove the edges of the bandages and measure each wound for Resident #7 with wound to right buttock 1.5 cm x 7.0 cm x 0.25 cm, new wound noted to right gluteal fold 0.5 cmx 1.25 cm x 0.1 cm, and wound to sacrum 10 cm x 7 cm. The DON did not measure the depth of the sacrum wound. Moderate amount of purulent drainage with odor noted. DON measured the wounds with a 4 x 4 gauze package and just pulled back the bandages and measured, she did not remove the dressings, just pulled the edges back.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 102	{F 686}		

On 5/17/2021 at 12:30 PM, in an interview with the emergency contact for Resident #7, she explained she is the resident's Responsible Party now. When asked if the facility has notified her of his wounds, she reported she was called about 2-3 weeks ago and notified of his wounds and that the resident needed wound care. She explained the Resident will start going to wound care at (Proper Name) Hospital. When asked does she know how long resident has had the wounds, she reported she not sure how long because the family has not able to come see the resident due to COVID-19 isolations and the resident has been out to the hospital. She denies any concerns with the facility other than it is hard to get in touch with the facility at times because no one will answer the phone.

Record review of a weekly body audit dated 07/07/2020 for Resident #7 revealed a sacrum wound Stage 3 with measurements 3 cm x 7 cm x 0.2 cm with bright red granulation tissue. The next body audit was dated for 12/17/2020 with sacrum wound and no measurements. A weekly body audit was done 02/06/2021 and 03/13/2021 revealed no measurements of wounds and treatments continue to coccyx and testicles as ordered. A weekly body audit dated 03/16/2021 revealed a sacrum wound with no staging of the wound, but wound measuring 3.5 cm x 1.8 cm x 0.2 cm completed by LPN #1. A weekly body audit dated 04/13/2021 revealed a new pressure ulcer to right buttock with no measurements.

Record review of weekly skin reports provided by the DON revealed wound measurements for Resident #7 on 03/15/21 facility acquired Stage 2 sacrum 1.8 cm x 3.5 cm x 0.1 cm and on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 103	{F 686}		

05/08/2021 stage 3 sacrum with 1.5 cm x 1 cm x 0.1 cm stage 3.

Record review of a Physicians Order dated 4/6/2021 revealed wound culture of Stage 3 sacral decubitus one time only for wound care.

Record review of a Physicians Order dated 07/07/2020 revealed Stage 3 to sacral/gluteal cleft cleanse with wound cleanser and pat dry, apply puracol to wound bed, cover with Opti foam dressing daily. This order was discontinued 04/06/2021 and a new order started on 04/06/2021 for Hydrogel apply to Stage 3 sacral decubitus topically one time cleanse area with wound cleanser and pat dry, cover with Opti foam dressing daily and as needed for dislodging/soiling. The wound care order started on 04/06/2021 was discontinued on 05/04/2021 and a new order was started cleanse Stage 3 sacral wound decubitus with ¼ strength Dakin's solution, apply calcium alginate to wound bed and cover with bandage one time a day. A physician order was noted for Boost supplement with meals started on 04/22/2021 and another order for Boost two times a day for wound healing started on 04/15/2021.

Record review of Nurse Progress notes dated for 04/08/2021 for Resident #7 revealed resident was sent out to the local hospital on 4/08/2021 with the hospital diagnoses of Sepsis and Urinary Tract Infection. Lab reports 04/08/2021 revealed abnormal complete blood count (CBC) with elevated white blood cell counts 19.2 and on 04/09/2021 CBC elevated level of 23.5, urinalysis with positive nitrites, large leukocytes, and urine culture with Escherichia coli, and wound culture collection date of 04/08/2021 with heavy growth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 104	{F 686}		

of pseudomonas aeruginosa.
Resident #7 returned to the facility on 04/13/2021 with a new order of order to start on 04/14/2021 cleanse sacral and hip wound with wound cleanser, pat dry, apply Aquacel Alginate foam pad apply to sacral and hip wound topically one time a day, Augmentin 875-125 milligrams give one tablet by mouth two times a day for infection for 7 days started on 04/13/21 and end 04/20/2021.

Record review of nurse progress notes dated 04/15/2021 revealed Resident #7 was sent back to local hospital for altered mental status but returned the same day.

Record review of nurse progress notes dated 04/18/2021 revealed Resident #7 was sent back out to the local hospital on 04/18/2021 and admitted with diagnoses of Urinary Tract Infection and Pneumonia and returned to the facility on 04/21/2021.

A new Physician order for Moxifloxacin 400 milligrams give one tablet by mouth one time a day related to Pseudomonas started on 04/21/2021 when Resident #7 returned from the hospital and order end date 04/28/2021.
Record review of wound culture of Resident #7's sacral wound collected on 04/22/2021 revealed heavy growth of pseudomonas aeruginosa with sensitivity report.

Record review of nurse progress notes on 04/26/2021 revealed Resident #7 was unresponsive and sent back to local hospital and resident returned to the facility on 04/29/2021 with diagnosis of Syncope with a new order for Ciprofloxacin 500 milligrams give one tablet by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 105	{F 686}		

mouth every 12 hours for wound infection for 14 days started on 04/29/2021 and end on 05/13/2021.

Record review of a Physicians Order dated 05/04/2021 revealed cleanse Stage 3 sacral decubitus with ¼ strength Dakin's Solution, apply calcium alginate to wound bed and cover with bandage one time a day for sacral wound.

Record review of Resident #7's Face Sheet revealed the Facility initially admitted on 9/4/2018 and readmitted on 4/13/2021 with the following Medical Diagnoses include Type 2 Diabetes Mellitus, Heart Failure, Cardiomegaly, Cerebral Infarction, and Essential Hypertension.

Record review of the Discharge Minimum Data Set (MDS) dated April 18, 2021, Section C revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 05, which means Resident #7 is severely cognitively impaired. Section G of the MDS revealed Resident #7 required extensive assistance with one (1) person for bed mobility and toileting, and extensive assistance with two (2) persons assist for transfers. Section H of the MDS revealed Resident #7 was always incontinent of bowel and bladder. Section M of the MDS revealed Resident #7 had only one Stage 3 wound.

Record review of Antibiotic Usage Surveillance Tool revealed Resident #7 was on three (3) different antibiotics related to wound infections.

Review of Braden scale for Resident #7 dated 09/30/2020 revealed a score of 16 which indicated low risk for developing pressure sores.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 106	{F 686}		

Record review of Resident #7's care plans printed on 05/07/2021 revealed a care plan initiated on 09/06/2018 and revised on 04/26/2021 resident has a potential for altered skin integrity related to immobility and incontinent episodes of bowel with goal to have no complications related to Stage 3 ulcer and interventions for weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue, and exudate. These records are inconsistence with wound measurements observed by the DON and SA.

Resident #12

On 5/6/21 at 2:55 PM, the SA observed the DON do a full body audit on Resident #12. The last weekly wound assessment given by the DON done on 5/3/21 with only a wound to left anterior kneecap noted. The full body audit with the DON revealed abrasions to both the left and right anterior knees and one left lower lateral leg venous ulcer above the ankle. The right anterior knee wound had scant amount serous drainage, no odor, and red granulation tissue noted. The left anterior knee wound had moderate amount of serous drainage, no odor, and red/pink granulation tissue. The venous ulcer to left lateral lower leg had no drainage, no odor, and pink granulation tissue. An assessment of the buttocks revealed three (3) open areas to right buttock and one (1) open area to left buttock. All the three (3) open pressure areas to the right buttock and the one (1) pressure area to the left buttock had minimal bloody drainage and no odor with red granulation tissue noted. The SA observed the DON measure the wounds to the right and left buttocks with her index finger and thumb and recorded measurements of right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 107	{F 686}		

buttock site #1 measured 0.5 cm x 0.5 cm x 0.1 cm, site #2 measured 1.0 cm x 1.0 cm x 0.1 cm, and site #3 measured 1.5 cm x 1.5 cm x 0.1 cm. The SA observed the DON measure the wound to the left buttock with her index finger and thumb and document measurements of 1.0 cm x 1.5 cm x 0.1 cm. The measurements for the right knee were 1.0 cm x 2.0 cm and the DON did not record a depth. The left knee measurements were 3.5 cm x 3.0 cm, and the DON did not record a depth measurement. The left lateral lower leg ulcer was not measured by the DON for measurements. She did not use any type of measuring instrument.

On 05/07/21 at 1:00 PM in an interview with Medical Records LPN #10, she explained there is no Braden Scales on file for Resident #12.

05-10-21 at 3:15 PM in an interview with Resident #12 when asked how and when he got his wounds, Resident #12 explained that he fell at home and got wounds to his legs. He reported he cannot walk and does not want to get up out of bed. Heexplained he goes to wound care he thinks every 2 weeks. He further explained the wounds on his buttocks come and go. He reported he can move freely in the bed and tries to move to relieve pressure. He reported that he gives himself bathes from the waist up.

On 5/11/21 at 1:55 PM, an observation of the DON performing a body audit and wound measurements on buttock wounds for Resident #12 revealed three (3) wounds to Resident #12's right buttock and one wound to the left buttock with the DON. The DON explained 2 of the wounds to Resident #12's right buttock was healed on the body audit done 5/8/21. DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 108	{F 686}		

measured wounds with a Q-tip applicator package and documented the measurements as right buttock wound #1 as 2.0 cm x 1.5 cm x 0.1 cm, right buttock wound #2 as 0.5cm x 0.5 cm, and 0.1 cm, and wound right buttock #3 as 1.0 cm x 2.0 cm x 0.1 cm. The left buttock had one wound with a measurement of 0.5 cm x 0.5 cm x 0.1 cm. The DON did not measure the abrasions to both knees and the left lateral lower leg venous ulcer.

On 5-13-21 at 9:30 AM in an interview with (Proper name wound clinic) Wound Care Nurse, RN #2, She explained Resident #12 was seen at the wound care clinic before he went into the nursing facility. She reported he was being treated for venous ulcers to both lower extremities and then resident had a fall and had to go to the facility. She explained Resident #12 was readmitted to the wound care clinic on 12-21-20 from the facility. She reported the first time he was treated for a pressure ulcer to right buttock on 1-7-21 and the resident had reported the wound had been there for about two (2) weeks. She reported the right buttock wound was facility acquired.

Record review of Resident #12's body audits revealed a weekly body audit on 10/31/2020 with wounds to right and left knee and left lower leg, with no measurements and the facility and was unable to provide any measurements. A body audit on 11/23/2020 with wounds right buttock with 2 open areas, with no measurements and were unable to provide any measurements. Resident #12 had no other weekly body audits completed until 05/07/2021. A weekly pressure injury record dated 04/19/2021 revealed a Stage 2 pressure wound to right buttock with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 109	{F 686}		

measurements 0.3 cm x 0.3 cm x 0 cc, but the report was not signed. A weekly body audit done on 05/06/2021 signed by the DON revealed wound to left buttock with measurements 1.0 cm x 1.5 cm x 0.1 cm, wound to right buttock 2.0 cm x 0.5 cm x 0.1 cm and had listed right knee wound and left knee wound with no measurements, and DON could not provide any measurements for the wounds to the knees. Another weekly body audit was provided to the SA with wounds to right buttock with measurements 1.5 cm x 1.0 cm no depth, right knee (front), with measurements 1.0 cm x 2.0 cm no depth, and left knee (front) with measurements 3.5 cm x 3.0 cm granulated and no depth. The weekly body audit was signed by LPN #10. Another weekly body audit was given to SA with date 05/08/2021 and signed by the DON with measurements but did not list sites of wounds, or types of the wounds.

Record review of Face Sheet revealed the facility initially admitted Resident #12 on 10/24/2021 and readmitted on 1/6/2021 with Medical Diagnoses of Unspecified Atrial Fibrillation, Peripheral Vascular Disease, Chronic Embolism, Morbid obesity, Pressure ulcer of right buttock Stage 2, Non-pressure chronic ulcers skin, Thrombosis of Unspecified Deep Veins of Unspecified Lower Extremity, Chronic Kidney Disease, and Essential Hypertension.

Record review of the Quarterly Minimum Data Set (MDS) dated April 16, 2021 Section C revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 14, which means that Resident #12 is cognitively intact. Section H of the MDS revealed resident is always continent of bladder and frequently incontinent of bowel.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 110 Section M of the MDS revealed Resident #12 had one Stage 2 ulcer. Record review of Resident #12's care plans revealed no care plans for wounds. Record review of Resident #12's Physician Orders revealed orders for A and D ointment to buttock topically two times a day with Nystatin and triamcinolone with start date 04/14/2021, hydrogel apply to Stage 2 buttock topically two times a day for decubitus buttock with a start date 12/31/2021, and a new order on 05/10/2021 for zinc oxide apply to buttocks. Resident also had order to send to the local wound care clinic every 2 weeks with start date 03/16/2021. An order with start date 01/01/2021 noted clean bilateral knees with normal saline, pat dry apply Promogran to wound beds, secure with border gauze and changer every 48 hours, and another order with start date 04/20/2021 cleanse wound to left and right anterior knee with normal saline, pat dry, apply Silvadene to wound bed and cover with a border dressing one time a day for wound care. Record review of Resident #12's Proper Name local wound clinic wound report revealed date 04/08/2021 wound to right buttock Stage 2 pressure ulcer with measurements of 0.3 cm x 0.3 cm x 0.01 cm. Record review of Resident #12's RD progress note for 04/21/2021 revealed Stage 2 right buttock with recommendations add double protein portions all meals and add Juven twice a day x 14 days for wound healing. There were no orders noted on Physician Orders for Juven. Resident #13	{F 686}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 111	{F 686}		

Observation on 05/06/21 at 10:00 AM, revealed LPN #6 provide wound care to Resident #13's left heel. The nurse cleansed the left heel with wound cleanser, applied Santyl and covered with kerlix. The wound was open and pink in the middle of the wound bed.

Record review for Resident #13's Face Sheet revealed the facility admitted Resident #13 initially on 04/04/2018 and readmitted on 11/30/2020 with diagnoses of Type 2 Diabetes Mellitus, High Blood Pressure, and Convulsions. The Face Sheet revealed Resident #13 was diagnosed with Pressure ulcer of left heel Stage 2 on 06/16/2021. Record review of Resident #13's Quarterly MDS with ARD date 04/28/2021 Section C revealed resident had a BIMS score of 02, which indicated severe cognitive impairment. Section M revealed Resident #13 had one Stage 2 pressure ulcer.

Record review of Resident #13's Physician Orders revealed order for heel protectors bilaterally due to skin breakdown on left heel start date 12/31/2020, betadine solution apply to left heel topically one time a day for 14 days started on 01/01/2021 and then restarted on 01/22/2021 for 10 days and then again on 02/02/2021. A new order for Santyl Ointment apply to left heel and cover with gauze dressing one time a day for wound care start on 03/03/2021. An order to inspect resident feet daily started on 04/14/2021.

Record review of weekly body audits for Resident #13 revealed resident had only one audit completed on 04/17/2021 with nothing listed and then a body audit on 05/08/2021 with description of pressure wound Stage 2 with eschar to left heel with measurements of length 5 cm and width

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 112	{F 686}		

5 cm. A weekly skin report completed by DON dated 05/03/2021 revealed facility acquired wound left heel with measurement of 3.5 cm x 3.5 cm, which indicated wound had increased in size from 05/03/21 to 05/08/21.

Resident #14

During an observation and interview on 5/6/2021 at 2:30 PM, SA observed the DON do a complete body audit on Resident #14. The body audit revealed an eschar area to left great toe healing. DON explained the area was an ulcer and she had been monitoring it, but it is getting better. The DON was observed measuring the wound with her index finger and thumb and charted 1 centimeter (cm) length and 2.5 cm width. She did not use any type of measuring instrument. The DON and SA observed scabbed area to Resident #14's left buttock with no dressing intact. The DON measured the area with her fingers again and recorded measurements of 2 cm length and 1 cm width. A hardened area noted to the left breast and the DON explained Resident #14 has breast cancer and area is being treated. No other skin issues were noted to Resident #14's skin.

On 05/17/2021 at 11:00 AM, in a phone interview with the Responsible Party for Resident # 14, when asked had she been notified of any wounds for Resident #14, she explained no she had not. She further reported the facility usually is good about letting her know of any changes in the resident but has not heard of any wounds the resident has or have had. She reports that she knows the resident is not very mobile and does sit a lot.

Record review of Resident #14's Face Sheet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 113	{F 686}		

revealed the facility initially admitted Resident #14 on 05/20/2015 and readmitted on 08/14/2018 with the diagnoses of Hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side, Depressive disorder, Slurred speech, and Alzheimer's Disease. The Face Sheet also revealed Resident #14 was diagnosed with Stage 2 pressure ulcer unspecified buttock 01/29/2021.

Record review of Resident #14's Quarterly MDS with ARD date of March 1, 2021, Section C revealed Resident #14 had a BIMS score of 15, which indicated cognitively intact. Section G revealed Resident #14 required total assistance with bed mobility and transfers with the assist of two or more persons, and total assist for toileting with assist of one person. Section H of the MDS revealed Resident #14 is always incontinent of bowel and bladder. Section M of the MDS revealed Resident #14 had no pressure, venous, or arterial ulcers, but did have moisture associated skin damage.

Record review of Resident #14's Physician Orders printed 05/10/2021 revealed orders for ensure hydrocolloid dressings are applied to left and right great toes and coccyx ulcers as ordered change dressings every 3 days and when visibility soiled as ordered date, initial, and time every dressing and document every dressing change in progress notes. The order was started on 01/10/2021 and discontinued on 03/15/2021 related to coccyx wound healed. An order was started on 03/16/2021 for ensure hydrocolloid dressings are applied to left and right great toes as ordered, change dressings every 3 days and when visibility soiled as ordered date, initial, and time every dressing and document every dressing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 114	{F 686}		

change in progress notes, and inspect resident's feet daily every shift, an order was started on 12/13/2021 for Hydrocol pad apply to left and right 1st toes ulcers topically every 72 hours, change dressings every 3 days and when visibility soiled and order discontinued on 04/09/2021 resolved.

Record review of Resident #14's weekly body audits revealed only 3 body audits prior to 05/07/2021. Weekly body audit dated 09/19/2020 revealed Resident #14 had redness to buttocks and treatment to left breast. Resident #14 had one weekly pressure injury record dated 01/11/2021 but report was incomplete, blank, no areas entered. A weekly body audit completed on 05/06/2021 completed by the DON with area to left great toe measuring 1 cm x 2.5 cm eschar and area to left buttock measuring 2 cm x 1 cm scab.

Record review of Resident #14's recent labs revealed an Albumin level 3.2, which is a low level.

Resident #17

On 5-7-21 at 2:00 PM, in a phone interview with Medical Nurse Practitioner, she explained she ordered a wound vac for Resident #17. She reported that resident goes to wound care at the local wound care clinic every 2 weeks. She explained she trained three nurses, the Assistant Director of Nursing (ADON), LPN #5, and LPN # 10 today for the wound vac and all three know how to work the wound vac for the resident.

Observation on 5/10/21 at 2:50 PM, revealed the DON measured Resident #17's sacrum and right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 115	{F 686}		

buttock. The wound to right buttock Stage 2 measured 4 cm x 3 cm x 0.1 cm, tissue pink/red with scant amount of bloody drainage noted. The Stage 4 Sacral Pressure Ulcer measured 12 cm x 10 cm x 4 cm with undermining at 9 and 12 o'clock. There was a moderate amount of serosanguinous drainage noted with a foul odor. The DON measured the wounds with a Q-Tip and then used a 4 x 4 gauze package for the measurements.

Observation on 5/10/21 at 3:00 PM, revealed LPN #5 and LPN # 10 perform wound care on Resident #17's Sacral Pressure Ulcer and apply wound vac. A Stage 4 wound noted with a large amount of odorous, purulent drainage. Wound vac with suction noted after completion and setting as ordered.

05-10-21 at 3:30 PM in an interview with Resident #17, when asked how and when he got his wounds, Resident #17 explained he has had left sided weakness for years, could walk, and he fell at home. He explained after he fell, he could not walk as much and sat in his recliner. He explained his brother-in-law would come up and change him. He further explained he had diarrhea for 3 days and his buttocks became very red, and his brother-in-law took a picture. He reported his buttocks looked like it had blood pooled around it. He was taken to the Veterans Hospital in Louisiana and then the local hospital. He reported he was septic and almost died. He explained one of the hospitals had to do a scraping of the wound and he had to get a colostomy. He reported that he does not remember giving consent for the colostomy, but he was so sick and took medications which made him more confused. He explained that his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 116	{F 686}		

choices were to go to a nursing facility or go home with hospice. He reports he is starting to feel better now.
On 5/10/21 at 4:00 PM, during an observation and interview with the DON, the SA observed the DON assess Resident #17's feet. The body audit revealed the left heel was very dry and scaley with a brown eschar area noted to left heel. The eschar measured 2 cm x 2 cm. The SA asked the DON regarding wounds on Resident #17's feet and she explained when resident did have some blackened areas on one of his heels and his toes but thinks the blackened areas all fell off and the heel wound was healed too.

On 5-11-21 at 10:00 AM, in an interview with Medical Nurse Practitioner, she explained she is not involved admissions. She explained she did not feel the facility did not have enough staff or education for taking care of the wound for Resident #17. She explained Resident #17 was a train wreck when he came in and has been sent out to hospital several times for evaluation and treatment and continue antibiotics for wound infection
.
On 5-13-21 at 9:30 AM, in an interview with Wound Care Clinic nurse, RN #2, When ask regarding Resident #17's wound care, she explained the wound care clinic has seen Resident #17 one (1) time on 4-29-21. She reported the clinic had a hard time getting his referral but got it straightened out. She reported the wound care clinic recommended the resident a wound vac and the Medical Nurse Practitioner works close with the wound care clinic and was to order the wound vac. She reported the resident's next appointment is next Thursday 5-20-21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 117 On 5-13-21 at 11:45 AM, in an interview with Medical Nurse Practitioner regarding wound care, she explained that wound care is not consistent in the building and that has become a problem with wounds. She explained the wounds will look good and then go bad. She explained the nurses do most of the wound care and the DON very seldom even looks at the wounds. She further explained the intravenous antibiotics are not given consistently either and she never knows if meds are given because the MARs are not signed. She reported that a nurse phoned her on Monday and explained to her the intravenous antibiotics were not available and a new order was given to give intramuscular. She further explained Am Pharm MSLLC consistently sends medication price reports and request medications to be changed due to the cost of the medications. When asked an example of what medication is denied she explained it has been antibiotic and wound care medications Santyl. She reported that she asks the DON, Administrator, and the admission lady who determined why we accepted Resident #17. The Nurse Practitioner explained she did not have any input on his admission and after he was admitted explained to the DON and Administrator the facility already had problems with wound care and Resident #17 required a lot of wound care with a wound like his and the facility is not capable to care for him. She reported he was admitted with osteomyelitis to his spine and requires more care. She explained the DON and Administrator explained to her the facility must get the census up and then the facility will be able to get a wound care nurse. Record review of Resident #17's Admission Record revealed the facility originally admitted Resident #17 on 3/4/2021 and readmitted on	{F 686}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 118	{F 686}		

3/10/2021 with the Medical Diagnoses of Osteomyelitis of Vertebra, Sacral and Sacrococcygeal Region, Unstageable Pressure Ulcer of Sacral Region, Congestive Heart Failure, Diabetes Mellitus due to Underlying Condition with Foot Ulcer, Chronic Obstructive Pulmonary Disease, Chronic Peripheral Venous Insufficiency and Essential Hypertension.

Record review of Resident #17's 5-day Minimum Data Set (MDS) with ARD of March 12, 2021 revealed the resident has a Brief Interview for Mental Status (BIMS) score of 15, which means that Resident #17 is cognitively intact. Section H of the MDS revealed Resident #17 had a catheter and colostomy. Section M of the MDS revealed Resident #17 had one unstageable wound due to non-removable dressing/device and one unstageable wound due to slough or eschar, diabetic foot ulcer and other open lesions on the foot.

Record review of Resident #17's Physician Orders from 03/01/2021 thru 05/31/2021 revealed orders for Boost Glucose three times a day. The most recent wound care orders dated 05/13/2021 cleanse sacral decubitus with ¼ strength Dakin's Solution, apply gentamicin sulfate powder to wound bed, pack wound with silver alginate, cut sponge to fit within wound bed, place wound vac at 125 pressure continuous suction change on Tuesday and Friday or sooner if there is suction malfunction, in case of wound vac malfunction, cleanse sacral decubitus with ¼ strength Dakin's solution, apply gentamicin sulfate powder to wound bed, pack wound with silver alginate and cover with bandage and notify provider. Stage 2 ulceration at site of urinary catheter insertion wound caused from pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 119	{F 686}		

from the catheter, cleanse area with soap and water, dry, apply mixture of A and D ointment, Nystatin ointment, and triamcinolone cream daily, and wound care follow up at Proper Name wound clinic on 05/20/2021. Resident #17 had order for body audit weekly and as needed. The Physician Orders revealed since Resident #17 had been admitted to the facility he has received oral, intramuscular, and intravenous antibiotics for wound infection, osteomyelitis, and gram-negative sepsis including Ceftriaxone 1 gram (gm) one time a day, Cipro tablet 500 milligram (mg) every 24 hours, clindamycin 300 mg, Levofloxacin 750mg/150 ml every 24 hours, Levofloxacin tablet 750 mg one time a day, and Meropenem 1 gm every eight hours.

Record review of Resident #17's Nurse Progress notes revealed on admission 03/04/2021 Resident #17 had a wound present to sacrum, three incision scars near umbilical area, wound to left heel, and black scar tissue visible to toes. Progress notes dated 03/05/2021 revealed Resident #17 was sent to the Local Hospital due to new colostomy and resident having bowel movements out of rectum and physician wanted to get evaluation of decubitus ulcer on coccyx. Resident #17 was admitted to the hospital on 03/05/2021 for urinary tract infection and osteomyelitis and sent back to the facility on 03/10/2021.

Received an incomplete Braden scale report and Baseline care plans for 03/04/2021 and 03/10/2021 from medical records on 05/10/2021 at 10:00 am for Resident #17.

Record reviewed of body audits and weekly pressure injury reports provided by the DON for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 120	{F 686}		

Resident #17 revealed a Body Audit dated 05/06/2021 and could not determine measurements or exact locations for Resident #17. Another weekly body audit dated 05/08/2021 with three wounds listed and only one measurement for sacrum wound 12 cm x 10.4 cm x 4 cm with serosanguinous drainage, muscle and bones exposed, and undermining at 9 and 12 o'clock, with notes indicating new debridement to sacrum wound, resident refused measurements of groin denuded area, and resident refuses to turn to right and lays on back. Received weekly pressure injury reports for Resident #17 on 05/11/2021 with dates 3/4/2021, 3/15/2021, 4/7/21, and two reports for 5/8/21. The reports were all for Resident #17's sacrum wound and revealed wound measured 10 cm x 8 cm x 0.1 cm on 03/04/2021 and measured 12 cm x 10 cm x 4 cm on 05/08/2021.

On 05/06/21 at 10:50 am interview with the DON, she explained she just started doing weekly wound care reports. She explained that she has not been consistent with doing wound reports. She explained the nurses on the med carts do the treatments and the measurements for each wound. When ask when the measurements are taken, she explained there is no special days to measure wounds. She reported no in services or special training regarding wound care has been done. She reported the only wound care training the nurses have had including her, are from school and she did wounds for Hospice before, but no wound care treatments were done in Hospice, she just kept the resident comfortable. She further explained that the nurse on the floor was to measure Resident #6's and Resident #3's wound today. SA explained the wound was not measured during wound care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 121	{F 686}		

On 5-6-21 at 1:00 PM in an interview with LPN #5, when ask about measuring wounds, she explained she has never measured any wounds including Resident #7. She further explained the DON ask her to measure wounds and she feels that the DON needs to look at the resident's wounds at least weekly. She explained the DON ask for our measurements for her report, but the DON does not look at wounds weekly and does not measure wounds.

On 5/6/21 at 1:00PM, in an interview with the Minimum Data Set (MDS) nurse, she explained that she in getting wound reports from the DON. he has tried to get information from the DON regarding wounds but has not been able to get any reports. She explained that every morning during the facility's stand -up meeting she ask for wounds and the DON said she has the reports but has never produced anything. She explained she obtained the information by going through the nurse and nurse practitioner notes. When asked if the facility has a system in place to check assessments prior to submitting the report, she reports since she has worked at the facility doing MDS assessments, she submits the assessments and then she lets the Corporate Office know when the assessments have been submitted.

On 5-6-21 at 1:30 PM in an interview with CNA #4, she explained she is the lead CNA, and does some in-services with the CNAs. When ask her regarding in-services with CNAs for skin changes with the residents, she explained the DON does in-services on the wounds and skins and she does not remember when the last one was done.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 122 5-6-21 at 5:00 PM in an interview with Registered Dietician when ask regarding wounds, she explained she does consults and record review for residents with wounds greater than a Stage 2 and will see residents with weight loss. She explained the resident she seen last month with wounds include Resident #3, Resident 7, Resident #12, and Resident #17. 5-6-21 at 5:30 PM in an interview with the Nurse Consultant, she explained the DON has not been consistent with wound care reports for months. She explained she has gone over the wound care with the DON and explained to the DON that she would need to assess the wounds weekly and would discuss the wounds weekly. She explained she has not been able to do patient at risk (PAR) notes due to no wound reports turned in. She further reported that about one (1) or two (2) months ago she asks the DON to do complete 100% body audits in the building but never received the audits. She explained she had been working as acting DON at a sister facility and not been able to follow-up on body audits. Explained to the Nurse Consultant that the SA has asked for weekly wound reports and only received one report with the date of 5-3-21 and other notes from the DON with names and measurements listed but no dates. The Nurse Consultant reported that the wounds are to be assessed on admission and weekly. 5-7-21 10:00 AM In an interview with DON, ask her how she measured the wounds yesterday with the body audits, she demonstrated with her thumb and index finger. She reported she measured with her fingers. She further explained that she has looked at wounds so much that she knows the measurements. When ask the appropriate way to measure wounds, she	{F 686}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 123	{F 686}		

explained with a ruler. She further explained she needs a little measuring tape and that she never knew how to measure with the circle measuring tool. She reported she likes to use a gauze with the wrapper to measure the wounds. She explained that she must send reports to America Health Technologies (AMT) who provides supplies, the facility Nurse Consultant, and the Dietician but again she explained she has been overwhelmed with the DON position and has not been consistent with would care reports.

On 5-7-21 at 12:45 PM in an interview with Administrator, he reported that the DON was MDS coordinator before stepping up to the DON position due to the previous DON left the facility due to COVID. He explained he knew that the new DON stepped into the position in December 2020. When asked if he knew that the facility was having problems with wounds, he explained yes, he was aware that she was having difficulty with wounds and that the Nurse Consultant was helping her with the wound reports but lately has not been able to help due to the consultant has been acting DON at a sister facility.

On 5-7-21 at 2:30 PM, in an interview with DON, the DON gave the SA wound care reports with dates for 1-28-21, 3-15-21, 3-17-21, 3-24-21, 3-26-21, 3-29-21, 4-1-21, 4-5-21, ad 4-13-21. The DON explained she knew she had some more wound reports somewhere and she found them in the floorboard of her car. She explained that she must take her work home with her sometimes. She further explained she again has not been consistent with wound care, but she had no wound care training except for working Hospice and school. She again explained the nurses on the floor have only had the wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 124	{F 686}		

training from nursing school. She explained there has not been any set days for the wounds, measuring wounds or her doing the wound reports, but each resident is scheduled for weekly body audits. She reported that she hopes to schedule wound measuring for Monday because she must have the weekly wound reports turned in to the nurse consultant on Thursday.

5-7-21 at 3:00 PM in an interview with DON, when asked which nurses were trained for wound vac, she explained she is not exactly sure who was trained on the wound vac, but she was not. When asked has she had any experience with wound vac, she explained no. When asked what the plan was with the wound vac if the wound vac were to malfunction and the three nurses LPN# 5, LPN #10, and ADON are not in the building, she explained she does not know that answer and will find out.

On 5-7-21 at 3:15 PM in an interview with the Nurse Consultant, she explained the DON is responsible for weekly skin wound reports and the weekly body audits are done weekly by the resident's nurse. She reported that in the facility policy a LPN can measure wounds, but LPN cannot stage wounds and the DON should see wounds weekly and do a wound assessment including measurements. When ask what the facility measures wounds with, she reports the facility has paper rulers and measures width side to side, height with head to toes, and use a Q-tip for measuring depth.

On 05-10-21 at 10:20 AM in an interview with the DON to review body audits with DON which she done last week and over the weekend, she explained she included all findings on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 125	{F 686}		

individual body audit sheets, and she measured all wounds and printed a non-pressure and pressure wound report. She explained wounds on Resident #14's coccyx wound, scab was gone and healed. She explained that Resident #12's wounds on his left buttock healed and one on right buttock healed but she assessed wounds as shear tears. DON questioned Corporative Consultant and Nurse Consultant if a gluteal fold wound is pressure, both replied it would depend on what it looked like and where it is. DON reported that she does not think it is a pressure wound. Reviewed report for Resident #7 with DON and Resident #7 only having one wound listed, she explained she is not sure maybe the wound on the right hip was healed.

On 05/20/21 at 12:30 AM in an interview with local Medical Doctor (MD) report she has concerns related to the facility does not complete appropriate wound assessments. The wound assessments are not done for several weeks at a time. The MD stated the Director of Nursing (DON) changes the wound care orders without permission because of the cost of the medication. The MD stated she has not been invited to the QAPI meetings because (proper name) is still the Medical Director. The MD stated she has met with the Administrator and DON about her concerns.

Removal Plan:
The deficient practice consisted of failure to ensure residents received care, consistent to prevent pressure ulcers, to promote the healing of pressure ulcers, prevent an infection, and prevent new ulcers from developing.
Noncompliance at F686 has affected Residents #3, #5, #6, #7, #12, #13, #14, and #17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 126	{F 686}		

The Certified Wound Care Nurse and MDS Coordinator assessed wounds for staging and treatment on 5/28/21 for Residents #3, #5, 6#, #7, #12, #13, #14, and #17 to ensure correct treatments are being provided and interventions are appropriate for the wounds identified. Any necessary changes to treatment and medications were reported to the Medical Director. Any physicians' orders were entered at that time and the care plans updated.
Residents #4, #8, #9, #10, #11, #15, & #16 Care Plans were assessed and updated with correct staging, treatment, and interventions. In addition:
On 5/22/21, the Charge Nurses, MDS Coordinator, and DON were provided an in-service to educate them regarding the failure to assess wounds weekly and to change, develop, or update the resident's care plan immediately when wounds change.
CNA competency training--including toileting techniques, turning, and positioning were completed by
6/1/21 by the Lead CNA.
On 6/03/21, Corporate Management approved for Wound Care Specialists from other facilities to work in the Facility to assist with audits of wounds, wound care, training, and assist with correcting care plans.
All Residents listed have been thoroughly assessed & reassessed regarding the wound care provided to them in the Facility. Care plans have been updated, and education has been provided to all staff regarding: measurements, Braden scale frequency, notification of families about new wounds and status of wounds, and documentation of care provided.
Beginning 5/6/21, all other residents' care plans were evaluated for behaviors and wounds, and a comprehensive plan of care was completed for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 127	{F 686}		

each resident.
The Care Plan Committee implemented comprehensive care plans for Residents #2, 3, 6, 7, 9, 10, 11, 14, 15, 17, 20, 30, and 31 on 5/21/2021 related to wounds and medications. Resident # 4 discharged on 1/29/20, Resident 5 discharged on 1/21/21, and Resident #12 discharged on 5/17/21.
The Regional Nurse Consultant contacted American Medical Technologies (AMT) to request an in-service for nursing staff related to skin and wounds on 5/21/21. AMT completed an evaluation of Facility residents' wounds on 6/4/2021 for any necessary additional changes.
The Nurse Practitioner was scheduled to attend a training and education with AMT on 6/4/21 to gain knowledge regarding assessing and staging wounds and the clarification of appropriate wound treatment orders.
The Assistant Director of Nursing completed skills competencies with the Regional Nurse Consultant on 5/21/2021 that included routine competencies, skin and wound, behavioral health, and medication administration.
On 5/22/21, the Regional Nurse Consultant conducted education for the Director of Nursing, ADON/ICC, and Medical Records Nurse regarding monitoring care plans, medication administration, wound care, pharmacy services, and communication with Governing Body.
Licensed nursing staff completed body audits on all patients on 5/23/2021, any new skin concerns were addressed at that time.
The wound care-certified Regional Nurse Consultant educated the Director of Nursing regarding the skin and wound care process including prevention, identification, treatment, documentation, wound vacs, and tracking and reporting wounds on 5/23/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 128	{F 686}		

The Regional Nurse Consultant and ADON/ICC began on 5/27/21 and completed on 5/29/21 a review of all residents' care plans for skin issues, therapeutic medications on their care plans, and any behaviors noted to ensure that the care plans are current and up to date.
Validation:
The State Survey Agency (SSA) validated through interviews with the Certified Wound Care Nurse and MDS Coordinator and review of pressure wound reports, body audits, and care plans, the Certified Wound Care Nurse assessed wounds for staging and treatment for Residents #3, #5, # 6, #7, #12, #13, #14, and #17 to ensure correct treatment and interventions were appropriate for wounds identified and any changes were reported to the Medical Director and care plans were updated as needed.
The SSA validated through review of pressure wound reports, body audits, care plans and interviews with Certified Wound Care Nurse and MDS Coordinator, Residents #4, #8, #10, #11, #15, and #16 were assessed, new skin issues were identified, and all orders and care plans were updated with correct staging, treatment, and interventions.
The SSA validated through record review and interviews the Comprehensive Care Plan for Resident #3 was updated to include the wound care clinic appointments, correct staging and current wound care orders for sacrum wound by the MDS Coordinator and Wound Care Nurse Specialist.
The SSA validated through record review and interview Resident #5 was discharged from the facility on 1/21/21.
The SSA validated through review of the Comprehensive Care plan and interview with the MDS Coordinator, Resident #6's care plan was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 129	{F 686}		

revised to include wounds.
The SSA validated through record review of the Pressure Wound Assessment, the Comprehensive Care Plan, and interviews with the Certified Wound Care Nurse and the MDS Coordinator, Resident #7 was assessed for wounds and the MDS Coordinator updated the care plan with the correct number of wounds and treatment.
The SSA validated through record review of the Pressure Wound Assessment, the Comprehensive Care Plan, and interviews with the Certified Wound Care Nurse and the MDS Coordinator, Resident #13 was assessed for wounds and the MDS Coordinator updated the care plan to include wounds.
The SSA validated through record review of the Pressure Wound Assessment, the Comprehensive Care Plan, and interviews with the Wound Care Nurse Specialist and MDS Coordinator, Resident #14 was assessed for wounds and the MDS Coordinator updated the care plan to include the treatment and intervention to the Stage 2 on the Buttocks.
The SSA validated through record review of the Pressure Wound Assessment, the Comprehensive Care Plan, and interviews with the Certified Wound Care Nurse and the MDS Coordinator, Resident #17 was assessed for wounds and the MDS Coordinator updated the care plan to include the correct staging of the wound on the left heel.
The SSA validated through interviews and review of In-Service sign sheet including content of in-services that Charge Nurses, MDS Coordinator, and Director of Nursing (DON) were in-serviced regarding the failure to assess wounds weekly and to change, develop, or update the resident's care plans when there is a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 130	{F 686}		

wound change.
The SSA validated through interviews and review of the competency training list competency training was completed by the Lead Certified Nursing Assistant (CNA) for CNA,s including toileting techniques, turning, and positioning of residents.
The SSA validated through interview with the Wound Care Specialists from another facility that he is currently on site at the facility to assist with audits of wounds, wound care, training, and correcting care plans until a person that is Wound Care Certified is hired.
The SSA validated through interviews with the Certified Wound Care Nurse and MDS Coordinator and review of pressure wound reports, body audits, care plans, and Inservice Sign-in sheets, the Certified Wound Care Nurse has assessed wounds for Residents #3, #5, # 6, #7, #12, #13, #14, and #17 and provided education to all nursing staff regarding wound measurements, Braden scale frequency, notification of families about new wounds and status of wounds, and documentation of wound care provided.
The SSA validated through review of an audit form completed by the ADON, MDS Coordinator, and Regional Nurse all Residents care plans were evaluated for behaviors and wounds and a comprehensive care plan completed as needed. Residents #2, #9, #20, #30, and #31 were identified through the audit as requiring a care plan for wounds and medications.
The SSA validated through review of the Comprehensive Care Plans, care plans were implemented for Residents #2, #3, #6, #7, #9, #10, #11, #14, #15, #17, #20, #30, and #31 to include wounds and medications.
The SSA validated through review of an in-service

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 131	{F 686}		

sign-in sheet a contracted consultant conducted an in-service for nursing staff and the nurse practitioner regarding wound care, wound prevention, assessing and staging wounds, and clarification of appropriate wound treatment orders. The SSA validated through an interview with a contracted consultant an assessment of the facility's wounds and care was completed by the contracted consultant as a tool to assist in the in-services.

The SSA validated through interview and record review of competency skills check off, the ADON completed skills competencies with Regional Nurse Consultant that included routine competencies basic review for nurses, dressing change, and skin and wound care.

The SSA validated through interviews and record review of In-Service sign in sheets, the Regional Nurse Consultant provided education for the DON, ADON, and Medical Records Nurse regarding care plans, wound care, and communication with the Governing Body.

The SSA validated through review of body audit forms that audits were completed on all patients by licensed nurses.

The SSA validated through record review of the In-Service sign in sheet, the Regional Nurse Consultant conducted a bundle in-service with DON regarding skin and wound care process including prevention, identification, treatment, documentation, wound vacuums, and tracking and reporting wounds.

The SSA validated through review of an audit form completed by the Regional Nurse Consultant and ADON/ICC, care plans were reviewed for skin issues, therapeutic medications and behaviors for all residents to ensure care plans are current.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 725}	Continued From page 132	{F 725}		
{F 725} SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, and record review, the facility failed to have sufficient nursing staff to meet the needs of the facility residents as evidenced by failure to protect residents from abuse (Residents #1, #6, #9), worsening pressure ulcers (Residents #3, #5, #12, #17), failure to administer medications timely	{F 725}	1. Effective 5/14/21, the Facility Management, with the assistance of Corporate Staff, has actively been recruiting nurses and nurse aides. Over the past several years, the Facility continues to employ agency staff as needed to keep staffing numbers within	7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 725}	Continued From page 133 (Residents #1, #5, #8, #10, #11, #12,#15 and #17), delay in incontinent care (Resident #8), failure to use lift for transfer Residents #2, #14), for 13 of 24 sampled residents out of a total of 65 residents in the building. The failure to have sufficient nursing staff placed residents in the facility at risk for serious harm, injury, impairment or death. The situation was determined to be an Immediate Jeopardy (IJ) on 05/21/2021 and was determined to exist on 3/17/2021 when a resident with known aggressive behaviors was admitted to the facility without an increase in staffing to ensure other residents were not physically and verbally abused. The IJ and Substandard Quality of Care (SQC) existed at CFR(S): 483.35(a)(1)(2)- Nursing Services. The IJ was not removed prior to exit on 05/26/2021 and was considered ongoing. The facility provided a Credible Removal Plan of IJ, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit in order to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interviews, record reviews, and in-service reviews. The facility provided evidence the facility had implemented corrective actions listed in the Credible Allegation of Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for 42 CFR 483.35(a)(1)(2) has been lowered from the scope and severity of a "L" to the scope and severity of an "F".	{F 725}	acceptable parameters. The Assistant Director of Nursing(ADON) reviewed the schedule on 5/21/21 and again on 5/24/21 and called in additional staff. On 5/24/21, the Corporate Owner approved for additional Facility staff/agency staff to bring staffing numbers up to acceptable levels and to provide resident care. Staffing in the general facility care area was increased that day on 5/24/21. Staffing was reviewed with the Facility management team, the Owner, and the Senior Director of Clinical Operations on 5/26/21. It was determined that the Facility had calculated its staffing ratio as one unit instead of two distinct units. Staffing in the general Facility care area was increased to meet state and federal staffing requirements. Effective 6/05/21, the Transportation Aide resumed assisting the ADON in creating the Certified Nurses Aides schedule. 2. All residents have the potential to be affected by the deficit practice cited. 3. Beginning 6/5/21 the schedule was completed two weeks in advance and was reviewed by the Administrator or Director of Nursing (DON) to ensure the schedule has adequate coverage. Daily, actual staffing is monitored by the ADON and/or Transportation/Lead CNA by reviewing the schedule and agency staff sign in sheet and verifying actual staff in the building. Effective 05/24/21 the ADON and/or Transportation/Lead CNA will be notified by facility staff if there is staff that fail to report for their assigned shift. When call-ins do occur, the ADON and /or Transportation/Lead CNA will attempt to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 725}	Continued From page 134 The facility will remain out of compliance at Scope and Severity of "F" that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Record review of the facility's, "Staffing" policy, dated 6/1/00, noted it is the policy of the facility to provide adequate staffing to meet the needs of the resident population. On 05/04/2021 at 1:14 PM, the State Agency (SA) observed Resident #1 pacing up and down the facility's hallway screaming and cursing loudly with his fist balled up and going in and out of other resident's room unsupervised. At the time of this observation, the facility had two (2) Licensed Practical Nurses (LPN) and six (6) Certified Nurse Aids (CNAs) working the Long-Term Care Unit where the resident lived. In a separate secured area of the facility, there was (1) LPN and 2 CNAs working the Alzheimers Dementia (AD) Unit. A review of the posted staffing sheet was consistent with staffing observed. On 05/06/21 at 10:45 AM in an interview with Certified Nursing Assistant (CNA) #7, revealed he had been a CNA at the facility for two years. CNA #7 explained that he has had to work overtime frequently lately due to needing staff. He explained he usually works 7-3 shift but has also work 7 AM to 11 PM shifts when needed. On 05/06/21 at 3:30 PM, an interview with CNA #12, revealed she was working a 12-hour shift today instead of the usual 8 hour shift scheduled. She further explained there is always problems	{F 725}	call in other staff to cover the shift as well as attempt to contact the staffing agency for assistance. If those attempts fail, one of the two will cover the shift as appropriate determined by the position that called in until relieved. If two nurses fail to report for duty on the same shift, then the ADON will call the DON for assistance. On 5/24/21, the Senior Director of Clinical Operations provided one on one education to ADON and Transportation Aide to include staffing based on acuity and layout, staffing patterns, and shifts. The ADON and the Transportation Aide were educated on nurse staffing and creating a stable staffing pattern for implementation. 4. Medical Records or Director of Nursing will audit staffing sheets daily times four weeks beginning 6/29/21 then monthly beginning 7/29/21 times three months. Findings will be brought to QAPI monthly beginning 7/2/21 for review, revision, or resolution of the plan for six months. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance. The Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 725}	Continued From page 135	{F 725}		

with enough staffing and the CNAs work short. She explained working short is hard on residents and the staff.
On 05/05/2021 at 10:00 AM in an interview with Resident #8, she explained she must wait for long periods of time for CNAs to answer call lights, approximately 30 minutes.
On 05/10/21 at 3:15 PM in an interview with Resident #12, revealed he uses a urinal but needs to have a brief changed occasionally due to bowel incontinence. He explained he must wait long periods of times to have the call light answered and cleaned up.
On 05/11/2021 at 12:00 PM in an interview with Resident #15, the resident explained sometimes it takes up to three (3) hours to get pain medications after he request medications and up to 30 minutes or longer to have a new brief changed . He reported he knows other residents are in need to, but he knows he needs to be taken care of and is tired of fighting with the facility.
On 05/11/21 at 4:45 PM in an interview with LPN #14 revealed on 05/09/21 on the 3-11 shift, it was just her and a CNA until after dinner. The nurse said she had to choose between giving medications and changing the resident's briefs.
On 05/12/21 at 10:00 AM in an interview with CNA #9, revealed she has been a CNA for 14 years and all this time has been at the current facility. She reported that she works the Dementia Unit 12 hours a day and usually there are 2 CNA working the unit but lately has only had one. She explained most of the time she works by herself with 14-16 Dementia residents since February 2020. She reported a nurse is always on the unit and sometimes it is a Registered Nurse (RN) but usually a Licensed Practical Nurse (LPN). She reported the nurse has never helped with resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 725}	Continued From page 136	{F 725}		

care, but sometimes will help pass out a tray. She reported that as of right now there is one resident with total care and cannot walk but the other residents walk. She stated that in the past, the Alzheimers Dementia (AD) Unit has had up to 5 residents for total care and 4 residents in a wheelchair. She explained Resident #20 requires a sit to stand lift daily. She further explained another resident, Resident #30 requires assist with a sit to stand frequently due to resident is inconsistent with standing on her own. She reported she has used the sit to stand lift by herself due to not having enough staff on the unit. She reported that she has reported short staffing to Director of Nursing (DON) and Assistant Director of Nursing (ADON) but nothing has been done about the staffing. She explained when using a sit to stand lift alone, a resident could be dropped, and reports she is not able to care for residents as needed due to short staffing. She stated also she felt that there has been a couple of falls on the Dementia Unit due to low staffing. She stated a resident's light was going off for at least 10 minutes, but she was assisting another resident with a shower and by the time she went to answer the light resident was on the floor, she reported another resident fell in the TV room while she was assisting another resident. She explained if there would be 2 CNAs on the unit one CNA could answer call lights while the other CNA is providing showers. She explained she has not been able to follow care plans due to not having enough staff and this could be a hazard to all residents on the unit.
Interview on 5/13/21 at 12:32 PM with CNA # 9 said she has had to work the AD unit without another CNA more than one occasion and has had to transfer residents via sit to stand and full body lifts without assistance due to the nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 725}	Continued From page 137	{F 725}		

cannot assist because she could not leave the residents with behaviors. The CNA said on one occasion she was in the room with a nurse transferring a resident via Hoyer and one of the behavior residents started acting out and they had to run out in the hall to stop the resident from hitting another resident. She stated that using a stand with one (1) person instead of two (2) could get residents hurt and maybe even dropped from a lift.

Interview on 5/13/21 at 12:32 PM with CNA #8 confirmed she has been on the Alzheimer's unit without another CNA more than once and voices concerns for the residents and herself. She explained that it is hard to watch the elders with behaviors and to provide care for other residents. The CNA said she had to transfer residents via Hoyer lift without assistance because the nurse had to monitor the other residents with behaviors. The CNA said she was in-serviced about the care plans and know the staff should follow the plan of care but some of the residents cannot transfer themselves according to the care plans. The staff must do whatever it takes to transfer the resident.

On 5/20/21 at 09:15 AM, the DON revealed she has never read the Federal regulations for nursing homes and is not aware of what each regulation means. The DON revealed because of the facility's budget, her hands were tied regarding staff, and she was not allowed to bring in contract workers anymore. She explained the facility did use agency staffing in December after being cited for staffing concerns, but not since then. The DON reported the facility had 4 residents on the Alzheimer's unit that could not transfer independently. The DON confirmed if there's not enough staff to take care of the resident's this could cause a negative outcome. The DON explained she was told by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 725}	Continued From page 138	{F 725}		

Administrator the facility does not have the money or the numbers to get the staff.
On 5/20/21 at 10:00 AM with Regional Director of Operations Manager, revealed the current facility assessment does not guide the facility on staffing and how to meet the needs of the residents. The administrator is responsible for having an appropriate facility assessment including staffing needs. The Operations manager said the deficient practice started from the COVID pandemic prior to the DON because the facility did not have enough staff.
On 05/20/21 at 12:30 PM interview with Physician #2 said the facility does not have enough staff to meet the needs of the residents. The physician said she takes care of all the residents' medical needs along with her nurse practitioner but also relies on the nursing staff to informed of any issues related to resident's care. The physician also explained she reported several issues to the State Agency in December about low staffing problems.
Review of the December 2020 survey by the state agency revealed the facility received a citation due to low staffing numbers that failed to meet the residents' needs.
On 05/20/21 at 1:00 PM interview with the Medical Director revealed he is on a month-to-month contract with the facility. The Medical Director revealed he is part of the QAPI team he attends the meetings monthly. The physician said he was aware of the low staffing problems but thought the facility was working on the problem and had corrected the problem. The physician explained he did not report this to the SA or the AG's Office, but he did talk to the corporate people about the problem. He further explained he thought the Administrator said the facility was going to bring in Agency staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 725}	Continued From page 139 On 05/20/21 at 2:00 PM interview with the Administrator revealed the administrator is responsible for writing the Facility Assessment, but it is not sufficient to assist the facility in meeting the needs for staffing in order to meet the care needs of the residents in this building. The Administrator also confirmed the Facility Assessment does not give guidance on competent staffing. The Administrator confirmed the facility should have known they did not have sufficient/competent staff to take care of the needs of the residents. The Administrator confirmed the facility have system failures with staffing. Removal Plan: The deficient practice consisted of failing to have sufficient staff to protect residents from abuse, worsening pressure ulcers, failure to administer medications timely, delay in incontinent care, and failure to use lift for transfer. Noncompliance at F725 has affected the following residents: Failure to Protect Residents from Abuse: Residents: #1, #6, #9 Worsening Pressure Ulcers: Residents: #3, #5, #12, #17 Failure to Administer Medications: Residents #1, #5, #8, #10, #11, #12, #15, & #17 Delay in incontinent Care: Resident: #8 Failure to use Mechanical Lift for Transfer: Residents: #2 and #14 Effective 5/14/21, the Facility Management, with the assistance of Corporate Staff, has actively been recruiting nurses and nurse aides. The Facility continues to employ agency staff as needed to keep staffing numbers within acceptable parameters. The ADON reviewed the schedule on 5/21/21 and again on 5/24/21 and called in additional staff. On 5/24/21, the Corporate Owner approved for	{F 725}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 725}	Continued From page 140	{F 725}		

additional Facility staff/agency staff to bring staffing numbers up to acceptable levels and to provide resident care.
Staffing was reviewed with the Facility management team, the Owner, and the Senior Director of Clinical Operations on 5/26/21. It was determined that the Facility had calculated its staffing ratio as one unit instead of two distinct units. Staffing in the general Facility care area was increased to meet state and federal staffing requirements.
Effective 6/05/21, the Transportation Aide resumed assisting the ADON in creating the Certified Nurses Aides' schedule. The schedule will be completed two weeks in advance and will be reviewed by the Administrator and/or Senior Director of Operations to ensure the schedule has adequate coverage. Daily, actual staffing is monitored by the ADON and/or Transportation/Lead CNA by reviewing the schedule and agency staff sign in sheet and verifying actual staff in the building. Effective 05/24/21 the ADON and/or Transportation/Lead CNA will be notified by facility staff if there is staff that fail to report for their assigned shift. When call-ins do occur, the ADON and [or Transportation/Lead CNA will attempt to call in other staff to cover the shift as well as attempt to contact the staffing agency for assistance. If those attempts fail, one of the two will cover the shift as appropriate determined by the position that called in until relieved. If two nurses fail to report for duty on the same shift, then the ADON will call the DON for assistance.
On 5/24/21, the Senior Director of Clinical Operations provided one on one education to ADON and Transportation Aide to include staffing based on acuity and layout, staffing patterns, and shifts. The ADON and the Transportation Aide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 725}	Continued From page 141	{F 725}		

were educated on nurse staffing and creating a stable staffing pattern for implementation.
Validation:
The SSA (State Survey Agency) validated through interviews with nursing staff including Registered Nurses (RNs), Licensed Practical Nurses, (LPNs), and Certified Nurse Assistants (CNAs) across all disciplines and shifts, the facility continues to employ agency staff as needed to keep staffing numbers within acceptable parameters.
The SSA validated through interview with the Assistant Director of Nursing (ADON), and record review of the nursing schedule revealed ADON reviewed the schedule and called in additional staff.
The SSA validated through record review of the staffing schedule and interview with the Assistant Director of Nursing (ADON), the staffing is calculated now with two (2) distinct units.
The SSA validated through interview with the ADON, the Transportation Aid assists the ADON in creating the CNA schedule at least two weeks in advance and the ADON monitors staffing schedule and agency staff sign in sheets daily to verify scheduled staff is in the building. The Senior Director of Operations verified the Administrator or the Senior Director of Operations reviews the schedule for coverage. The ADON verified facility staff contacts the ADON or the Transportation/Lead CNA if staff does not report as scheduled for their assigned shift and the ADON or the Transportation/Lead CNA will find coverage and will report to the DON in the event two nurses fail to report for duty on the same shift.
The SSA validated through interview with the Lead CNA and ADON and record review of in-service sign in sheet, an in-service was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 725}	Continued From page 142 conducted by the Senior Director of Clinical Operations regarding the subject of staffing on acuity, staffing patterns, and shift revealed education was provided for ADON and Lead Certified Nurse Assistant (CNA).	{F 725}		
{F 726} SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	{F 726}		7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 726}	Continued From page 143 This REQUIREMENT is not met as evidenced by: Based on staff, resident, Nurse Consultant, Nurse Practitioner and Medical Doctor interviews, Owner of the facility, observations of staff and residents, and record review the facility failed to ensure residents received care from competent staff to promote wound healing during wound care and while using a wound vacuum (vac for four (4) of eight (8) Residents. Residents #7, #12, #14 and #17. The failure to ensure residents received competent care, with wound vac usage, to promote wound healing placed the residents in a situation that caused or is likely to cause serious harm, injury, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) on 05/05/2021 and was determined to exist on 3/17/21, when Resident #1 was admitted with severe mental illnesses, with staff had insufficient training in severe mental illnesses training. The IJ and Substandard Quality of Care (SQC) existed at CFR(S): 483.35(a)(3)(4)(c) - Nursing Services. The IJ was not removed prior to exit on 05/26/2021 and was considered ongoing. The facility provided a Credible Removal Plan of IJ, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit in order to determine if corrective actions implemented by the facility were able to demonstrate removal of the	{F 726}	1. On 5/22/21 Resident #17□s wounds were measured, wound vac checked for correct placement, functioning properly, all of his wounds were dressed by the Certified Wound Care Nurse and Assistant Director of Nursing/Infection Control Coordinator(ADON/ICC), per the physician□s orders. Any necessary changes in treatment and medications identified were reported to the physician. Any physician orders were entered at that time and the care plan updated. Upon notification on 5/27/21, Residents #3, #6, #7, #12, and #14□s wounds were measured by the Certified Wound Care Nurse and dressed by the ADON/ICC, per the Medical Director□s order. On 5/28/21, the Owner of the Company hired an Independent Consultant that started assisting immediately with additional training, auditing, monitoring, and guidance for the Facility management. On 6/9/21 a consulting agency was engaged to assist with monitoring, auditing, and conducting training. On 5/31/21, the Independent Consultant and Regional Nurse Consultant reviewed the Wound Care Protocol, Wound Vac policy, and Measurement procedure for any necessary changes. No recommendations were suggested. On 6/1/21, the Independent Consultant and the Regional Nurse Consultant reviewed the Competencies for Wound Vac, Measurements, and wound dressings with no recommendations suggested. Effective 6/10/21, the Director of Nursing was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 726}	Continued From page 144	{F 726}		

immediate jeopardy.
The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interview, resident interview, family interview, record review, in-service review, and observation. The facility provided evidence the facility had implemented corrective actions listed in the Credible Allegation of Removal Plan of IJ. The IJ was determined to be removed on 6/12/21.
Upon validation, the IJ for 42 CFR 483.35(a)(3)(4)(c) has been lowered from the scope and severity of a "K" to the scope and severity of an "E".
The facility will remain out of compliance at Scope and Severity of "E" that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.
Findings Include:
The facility's policy, "Skin Care Process" dated 01/17/2018, "It is the policy of this facility to provide care and services with the goal of maintaining the resident's skin integrity and to provide care and services that meet the need professional standards to treat the loss of skin integrity should it occur ...6. Nursing staff should receive training regarding skin and skin care as appropriate upon on hire and periodically thereafter. Nurses may need further training in evaluation, assessments, staging and measuring wounds prior to being responsible for wound care."

An observation on 5/6/21 at 2:30 PM, with the

terminated from her position and an interim Director of Nursing was appointed.
2. All residents with skin integrity concerns have the potential to be affected by the deficit practice cited.
3. Beginning 5/6/21 and ending 6/10/21, the Certified Wound Care Nurse, and/or Regional Nurse Consultant conducted multiple mandatory in-services with all nurses (Registered Nurse, Licensed Practical Nurse, Certified Nurse Aides) concerning wound care including wound care protocol, standing orders for wound care, documentation, wound vac, and how to measure wounds. These in-services were either in-person, in a classroom setting or, 1:1, either in person or by telephone. Any staff missing in-services will not work until they receive the education. Any staff who fail to comply with the points of the in-services will be further educated and/or progressively discipline will begin as indicated.
Beginning 5/28/21 through 6/6/21, the Regional Nurse Consultant and Certified Wound Care Nurse began training on competencies for wound care including measurements, protocol, documentation, reporting, and following MD orders. Competencies with full-time staff were trained by observation, testing, or verbal statements concerning the process. Any staff on Family Medical Leave of Absence, PRN (as needed) staff, or agency not working during the competency checks will not work until they have completed the competencies. Competencies are completed on hire, and annually for all employees. Beginning 6/1/21 and 6/2/21,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 726}	Continued From page 145 Director of Nursing (DON) was observed measuring wounds with her index finger and thumb and charted 1 centimeter (cm) length and 2.5 cm width. She did not use any type of measuring instrument. State Agency (SA) observed DON measured Resident #14 wound area with her fingers and recorded measurements 2 cm length and 1 cm width. On 5/6/21 at 2:55 PM, an observation of the DON doing a full body audit on Resident #12. An assessment of the buttocks revealed three (3) open areas to right buttock and one (1) open area to left buttock. Observed DON measure wounds to buttocks with index and thumb and recorded measurement of Right buttock site #1) 0.5 x 0.5 x 0.1 cm, site #2) 1 x 1 x 0.1 cm, and site #3) 1.5 x1.5 x 0.1 cm. Observed DON measure wound to left buttock with index fingers and thumb and document measurements of 1 x 1.5 x 0.1 cm. She did not use any type of instrument to measure the wound. An observation on 5/11/21 at 2:30 PM, revealed wound care on Resident #7 the DON did not measure the depth of the sacrum wound. On 5/05/21 at 1:30 PM, in an interview with LPN #5, reported she does the treatments, but she does not measure the wounds and the DON is responsible for keeping up with the measurements. On 5/5/2021 at 3:00 PM, in an interview with the DON, when asked if a treatment is not initialed what does that mean, she stated," if it is not documented than it is not done". She further explained the treatments should be initialed after the treatment is done.	{F 726}	the Certified Wound Care Nurse and Minimum Data Set Coordinator conducted skin assessments on all other residents for skin issues. The Comprehensive care plans were checked on all residents for potential skin issues and updated based on findings from the assessments. Staff competency checklist form was created to ensure completion for all staff including agency. 4. Assistant Director of Nursing or Medical Records director will monitor staff competency for completeness bi-monthly beginning 7/1/21. Findings will be brought to QAPI monthly beginning 7/1/21 for review, revision, or resolution of the plan for six months. Independent monitoring by an outside consulting firm beginning 6/7/21 is being performed for compliance assistance. The Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 726}	Continued From page 146	{F 726}		

On 05/06/21 at 10:50 AM, in an interview with the DON, she explained she just started doing weekly wound care reports. She explained that she has not been consistent with doing wound reports. She explained the nurses on the med carts do the treatments and the measurements for the wounds. DON stated there is no specific days to measure wounds. She reported there has not been any in services or special training regarding wound care. She reported the only wound care training the nurses have had including her, are from school and she did wounds for Hospice before, but no wound care treatments were done in Hospice, she just kept the resident comfortable. She further explained that the nurse on the floor was to measure Resident #6's and Resident #3's wound today. SA explained the wound was not measured during wound care.

In an interview with LPN #5, on 5/6/21 at 1: 00PM, she stated she has never measured any wounds including Resident #7. She stated that the DON asked her to measure wounds. She stated she feels that the DON needs to look at the resident's wounds at least weekly. She explained the DON asked for our measurements for her report, but the DON does not look at wounds weekly and does not measure wounds.

On 5/6/21 at 5:30 PM, in an interview with the Nurse Consultant, she explained the DON has not been consistent with wound care reports for months. She explained she has gone over the wound care with the DON and explained to the DON that she would need to assess the wounds weekly and would discuss the wounds weekly. She explained she has not been able to do patient at risk (PAR) notes due to no wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 726}	Continued From page 147	{F 726}		

reports not being turned in. She further reported that about one (1) or two (2) months ago she asks the DON to do complete 100% body audits in the building but never received the audits. The SA explained to the nurse consultant that the SA has asked for weekly wound reports but received one report with the date of 5-3-21 and other notes from the DON with names and measurements listed but no dates. The nurse consultant reported that the wounds are to be assessed on admission and weekly.

On 5/7/21 at 10:00 AM, in an interview with DON, asked her how she measured the wounds yesterday with the body audits, she demonstrated with her thumb and index finger. She reported she measured with her fingers. She further explained that she has looked at wounds so much that she knows the measurements. When ask the appropriate way to measure wounds, she explained with a ruler. She further explained she needs a little measuring tape and that never knew how to measure with the circle measuring tool. She reported she likes to use a gauze with the wrapper to measure the wounds. She explained that she must send reports to formal Technology name, the facility Nurse Consultant, and the dietician but again she explained she has been overwhelmed with the DON position and has not been consistent with would care reports.

On 5/7/21 at 10:10 AM in an interview with the Assistant Director of Nurses (ADON), she explained she has nothing to do with the wounds and DON is the individual who does wound reports and monitors wounds.

On 05/07/21 at 1:00 PM, in an interview with Medical Records LPN #10, she explained there is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 726}	Continued From page 148	{F 726}		

no Braden Scales on file for Resident #12.

On 5/7/21 at 2:00 PM, in a phone interview with Medical Nurse Practitioner, she explained she ordered a wound vac for Resident #17. She reported that resident goes to wound care at a local wound care clinic every 2 weeks. She explained she trained three nurses, Assistant Director of Nursing (ADON), LPN #5, and LPN # 10 today for the wound vac and all three know how to work the wound vac for the resident.

On 5/7/21 at 2:30 PM, in an interview with DON, the DON gave the SA wound care reports with dates for 1-28-21, 3-15-21, 3-17-21, 3-24-21, 3-26-21, 3-29-21, 4-1-21, 4-5-21, ad 4-13-21. She explained she knew she had some more wound reports somewhere and explained she found them in the floorboard of her car. She explained that she must take her work home with her sometimes. She further explained she again she has not been consistent with wound care, but she had no wound care training except for working Hospice and school. She again explained the nurses on the floor has only had the wound training from nursing school. She explained there has not been any set days for the wounds measuring wounds or her doing the wound reports, but each resident is scheduled for weekly body audits. She reported that she hopes to schedule wound measuring for Monday because she must have the weekly wound reports turned in to the nurse consultant on Thursday.

On 5/7/21 at 3:00 PM, in an interview with DON, when asked who the nurses were trained for wound vac and she explained she is not exactly sure who was trained on the wound vac, but she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 726}	Continued From page 149	{F 726}		

was not. When ask has she had any experience with wound vac, she explained "no". When asked what the plan was with the wound vac if the wound vac malfunctions and the three nurses are not in the building, she explained she does not know that answer will find out.

On 5/7/21 at 3:15 PM, in an interview with Nurse Consultant she explained the DON is responsible for weekly skin wound reports and the weekly body audits are done weekly by the resident's nurse. She reported that in the facility policy an LPN can measure wounds, but LPN cannot stage wounds and the DON should see wounds weekly and do a wound assessment including measurements. When ask what the facility measures wounds with, she reports the facility has paper rulers and measures width side to side, height with head to toes, and use a Q-tip for measuring depth.

On 5/10/21 at 10:20 AM, in an interview and record review, with the DON, to review body audits with DON which was completed last week and over the weekend by the DON. she explained she included all findings on the individual body audit sheets, and she measured all wounds and printed a non-pressure and pressure wound report. She explained wounds on Resident #14's coccyx wound, scab was gone and healed. She explained that Resident #12's wounds on his left buttock are healed and one on the right buttock is healed but she assessed the wounds as shear tears. DON questioned Corporate Consultant and Nurse Consultant if a gluteal fold wound is pressure, both replied it would depend on what it looked like and where it is. DON reported that she does not think it is a pressure wound. Reviewed report for Resident #7 with DON and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 726}	Continued From page 150	{F 726}		

Resident #7 only having one wound listed, she explained she is not sure maybe the wound on the right hip was healed. Explained to DON, she will need to do another body audit with SA. DON explained she will come get SA for the body audits.

On 5/10/21 at 3:30 PM, in an interview with Resident #17, he stated that his choices were to go to a nursing facility or go home with hospice. He reports he is starting to feel better now. While in Resident #17's room the wound vac started to beep. SA went and got DON regarding the machine beeping she went into the room and explained the machine's battery is low and she will plug it up.

On 5/10/21 in an interview with DON at 4:00 PM, asked the DON regarding wounds on Resident #17, she explained resident did have some blackened areas on one of his heels and his toes but thinks they blackened areas all fell off.

On 5/11/21 at 8:00 AM, in an interview with the DON, she explained during the night Resident #17's wound vac lost suction and he refused to have the dressing changed and the provider was notified.

On 5/11/21 at 10:00 AM, in an interview with Medical Nurse Practitioner, she stated she felt like the facility did not have enough staff or education for taking care of Resident #17 wounds. She explained Resident #17 was a train wreck when he came in and has been sent out to hospital several times for evaluation and treatment and continue antibiotics for wound infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 726}	Continued From page 151	{F 726}		

On 05/11/21 at 2:20 PM, in an interview with DON prior to doing wound measurements on Resident #7, DON asked SA if she could just pull-down bandage and measure resident's wounds. While doing Resident #7's wound measurements, she explained she does not know where she got only one wound measurement for Resident #7 on 05/08/21. She further explained the area to Resident #7's right gluteal fold is new. While measuring the sacral wound, she reported "the wound stinks."

On 5/13/21 at 11:45 AM, in an interview with Medical Nurse Practitioner regarding wound care, she explained that wound care is not consistent in the building and that has become a problem with wounds. She explained the wounds will look good and then go bad. She explained the nurses do most of the wound care and DON very seldom looks even at the wounds. Resident #17 required a lot of wound care with a wound like his and the facility is not capable to care for him. She reported he was admitted with osteomyelitis to his spine and requires more care.

On 05/17/2021 at 11:00 AM, in a phone interview with Resident #17's Resident Representative (RR), when asked had she be notified of any wounds to resident, she explained no she had not.

On 5/17/21 at 3:00 PM, in an interview with the Administrator, he stated that he discussed in the Quality Assurance (QA) meeting with the DON. He stated the facility discussed wounds in the April 2021 QA meeting. The DON needed wound care training. The recommendation was for the DON to follow the NP for training and to send the residents with large wounds to wound care. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 726}	Continued From page 152	{F 726}		

DON is responsible for assessing and measuring the wounds weekly. The DON will do the weekly reports and notify the doctor and RR of the residents wound status. The DON said she never got the chance to receive the training from the NP. The DON said she has not had any training since nursing school.

On 5/20/21 at 9:15 AM, in an interview with the DON confirmed she did not have training to care for residents with wound Vac's. The DON also confirmed the residents admitted in the last three (3) months should not have been admitted because the staff was not competent to meet their needs. The DON said most of the nurses are new grads and have not been educated on wound care, medications, and behaviors.

On 5/20/21 at 10:00 AM, in an interview with Regional Director of Operations (RDO) stated the staff needs more education on wound care.

On 05/20/21 at 12:30 AM, in an interview with local Medical Doctor (MD) she reported she has concerns related to the facility does not complete appropriate wound assessments. The wound assessments are not done for several weeks at a time. The MD stated the Director of Nursing (DON) changes the wound care orders without permission because of the cost of the medication.

On 5/20/21 at 2:30 PM in an interview with the owner, stated he was aware of the staffing issues. He stated he was not aware of the severity of it.

On 5/20/21 at 3:00 PM, in an interview with the Administrator, he confirmed the facility should have known they did not have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 726}	Continued From page 153	{F 726}		

sufficient/competent staff to take care of the needs of the residents.

A record review of weekly body audit for Resident #7 revealed a sacrum wound Stage 3 with measurements 3 cm x 7 cm x 0.2 cm with bright red granulation tissue. The next body audit dated for 12/17/2020 with sacrum wound and no measurements. A weekly body audit noted for 03/16/2021 with sacrum wound measuring 3.5 cm x 1.8 cm x 0.2 cm. A weekly body audit noted for 04/13/2021 revealed new pressure ulcer to right buttock with no measurements.
A record review of weekly skin reports provided by the DON revealed wound measurements for Resident #7 on 03/15/21 facility acquired Stage 2 sacrum 1.8 cm x 3.5 cm and 0.1 cm and on 05/08/2021 stage 3 sacrum with 1.5 cm x 1 cm x 0.1 cm stage 3.

A record review of body audits revealed weekly body audit on 10/31/2020 with wounds to right and left knee and left lower leg, body audit on 11/23/2020 with wounds right buttock with 2 open areas, and no other weekly body audits completed. A weekly pressure injury record dated 04/19/2021 revealed a wound to right buttock with measurements 0.3 cm x 0.3 cm x 0 cm. A weekly body audit done on 05/08/2021 by DON did not list sites of wounds. Record review of the local hospital wound report revealed date 04/08/2021 wound to right buttock Stage 2 pressure ulcer with measurements of 0.3 cm x 0.3 cm x 0.01 cm.

A record review of Resident #14's weekly body audits revealed only 3 body audits prior to 05/07/2021. Weekly body audit dated 09/19/2020 revealed Resident #14 had redness to buttocks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 726}	Continued From page 154	{F 726}		

and treatment to left breast. Resident #14 had one weekly pressure injury record dated 01/11/2021 but report was incomplete, blank, no areas entered. A weekly body audit completed on 05/06/2021 completed by the DON with area to left great toe measuring 1 cm x 2.5 cm eschar and area to left buttock measuring 2 cm x 1 cm scab. 05/07/2021 revealed Resident #14 had black area on left big toe, no measurements documented.

A record review of the Braden scale on Resident #17 revealed it was incomplete.
A record review of body audits and weekly pressure injury reports from DON on 05/11/2021 at 10:00 AM for Resident #17 revealed a body audit dated 05/06/2021 and could not determine measurements or exact locations for Resident #17. Another weekly body audit dated 05/08/2021 with three wounds listed and only one measurement for sacrum wound 12 cm x 10.4 cm x 4 cm with serosanguinous drainage, muscle and bones exposed, and undermining at 9 and 12 o'clock, with notes indicating new debridement to sacrum wound, resident refused measurements of groin denuded area, and resident refuses to turn to right and lays on back. Received weekly pressure injury reports for Resident #17 on 05/11/2021 with dates 3/4/2021, 3/15/2021, 4/7/21, and two reports for 5/8/21. The reports were all for Resident #17's sacrum wound and revealed wound measured 10 cm x 8 cm x 0.1 cm on 03/04/2021 and measured 12 cm x 10 cm x 4 cm on 05/08/2021.

A record review of the latest in-service on Skin Care Process dated 1/7/21 revealed the signatures of LPN #5, LPN #6 and ADON.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 726}	Continued From page 155	{F 726}		

A record review of all the in-services revealed no training or sign in sheet for Wound Vac training.

Removal Plan:
The deficient practice consisted of failing to ensure residents received wound care to include the use of a wound vacuum by competent staff. Noncompliance at F726 impacted Residents #3, #6, #7, #12, #14, and #17.
On 5/22/21 Resident #17's wounds were measured, wound vac checked for correct placement, functioning properly, all of his wounds were dressed by the Certified Wound Care Nurse and ADON/ICC, per the physician's orders. Any necessary changes in treatment and medications identified were reported to the physician. Any physician orders were entered at that time and the care plan updated.
Beginning 5/6/21 and ending 6/10/21, the Certified Wound Care Nurse, and/or Regional Nurse Consultant conducted multiple mandatory in-services with all nurses (RN, LPN, CNAs) concerning wound care including wound care protocol, standing orders for wound care, documentation, wound vac, and how to measure wounds. These in-services were either in-person, in a classroom setting or, 1:1, either in person or by telephone. Any staff missing in-services will not work until they receive the education. Any staff who fail to comply with the points of the in-services will be further educated and/or progressively discipline will begin as indicated.
Upon notification on 5/27/21, Residents #3, #6, #7, #12, and #14's wounds were measured by the Certified Wound Care Nurse and dressed by the ADON/ICC, per the Medical Director's order.
Beginning 5/28/21 through 6/6/21, the Regional Nurse Consultant and Certified Wound Care Nurse began training on competencies for wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 726}	Continued From page 156	{F 726}		

care including measurements, protocol, documentation, reporting, and following MD orders. Competencies with full-time staff were trained by observation, testing, or verbal statements concerning the process. Any staff on FMLA, PRN staff, or agency not working during the competency checks will not work until they have completed the competencies.
Competencies are completed on hire, and annually for all employees.
On 5/28/21, the Owner of the Company hired an Independent Consultant to assist with additional training, auditing, monitoring, and guidance for the Facility management. On 6/9/21 a consulting agency was engaged to assist with monitoring, auditing, and conducting training.
On 5/31/21, the Independent Consultant and Regional Nurse Consultant reviewed the Wound Care Protocol, Wound Vac policy, and Measurement procedure for any necessary changes. No recommendations were suggested.
On 6/1/21, the Independent Consultant and the Regional Nurse Consultant reviewed the Competencies for Wound Vac, Measurements, and wound dressings with no recommendations suggested.
Effective 6/10/21, the Director of Nursing was terminated from her position and an interim Director of Nursing was appointed.
Beginning 6/1/21 and 6/2/21, the Certified Wound Care Nurse and MDS Coordinator conducted skin assessments on all other residents for skin issues. The Comprehensive care plans were checked on all residents for potential skin issues and updated based on findings from the assessments.
Validation:
The State Survey Agency (SSA) validated through interviews with the Assistant Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 726}	Continued From page 157	{F 726}		

Nursing/Infection Control Coordinator (ADON/ICC) and the Certified Wound Care Nurse and record reviews of Pressure Injury Reports and Comprehensive Care Plans, Resident #17's wounds were measured, wound vac checked for correct placement and proper functioning, treatment orders in place, and any changes in treatment were reported to the physician and added to the care plan.

The SSA validated through staff interviews and record review of in-service sign in sheets, the Regional Nurse Consultant/Certified Wound Care Nurse conducted in-services with all nursing staff either in-person, in a classroom setting or one on one, or by telephone, and any staff who failed to comply with in-service will not work until they receive the education. The in-services included information on wound care including wound care protocol, standing orders for wound care, documentation, wound vacuum, and how to measure wounds. The Regional Nurse Consultant verified through interview there were no nursing staff that failed to comply with the in-service.

The SSA validated through staff interview and record review of Weekly Pressure Injury Report for Resident's #3, #6, #7, #12, and #14, the wounds were measured by Certified Care Nurse and treatments completed by the ADON per the Medical Director's orders.

The SSA validated through staff interviews and record review of competency skills check off revealed the Regional Nurse Consultant/Certified Wound Care Nurse completed training on competencies for wound care including measurements, protocol, documentation, reporting, and following physician orders and competencies are completed on hire and annually for all nursing staff and no staff will be allowed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 726}	Continued From page 158 work until a competency has been completed for that staff member. The SSA validated through staff interviews and review of the contract with an Independent Consultant a consulting agency was engaged to assist with additional training, auditing, monitoring, and guidance for the Facility management. The SSA validated through an interview with the contracted consultant, the contracted consultant and the Regional Nurse Consultant reviewed the Wound Care Protocol, Wound Vac Policy, and Measurement procedure for any necessary changes and there were no recommended changes. The SSA validated through an interview with the contracted consultant, the contracted consultant and the Regional Nurse Consultant reviewed the Competencies for Wound Vac, Measurements, and wound treatments and there were no recommended changes. The SSA validated through staff interviews and review of the termination report, the DON was terminated from her position due to poor performance and an interim DON was appointed. The SSA validated through interviews and review of audits for skin assessments, the Certified Wound Care Nurse and conducted skin assessments on all residents and the Minimum Data Set (MDS) Coordinator updated all residents care plans based on the results of the audit.	{F 726}		
{F 740} SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest	{F 740}		7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 740}	Continued From page 159 practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, facility policy review, hospital discharge recommendations, the facility failed to provide Behavioral Health services when a resident was assaulted, and hair pulled by Resident #1 for one (1) of five (5) residents reviewed for behaviors, Resident #1. The failure to provide Behavioral Health Services and address known behaviors put Resident #6 and all other residents who reside in the facility at risk for serious harm, serious injury, serious impairment, or death. Resident #1 was witnessed with aggressive behaviors including yelling, cursing, threatening, and physically touching other residents. This situation was determined to be an Immediate Jeopardy (IJ), which began on 3/17/21 and determined to exist on 4/20/21. The IJ was not removed prior to exit on 5/26/21 and was considered ongoing. The IJ and Substandard Quality of Care (SQC) existed at CFR(S): 483.40 - Behavioral Health Services The IJ was not removed prior to the State Agency (SA) exit on 5/26/2021 and was considered	{F 740}	1. Resident #6 was evaluated by the Social Services Director on 4/20/2021 for any psychosocial needs and evaluated again by the Psychiatric Nurse Practitioner on 5/07/21. The resident received Pastoral Consultation on 5/25/21. Resident #1 was sent out and admitted to behavioral health on 4/21 and again on 5/4/21. The resident was discharged to behavioral health on 05/07/21. The Psychiatric Nurse Practitioner visited residents with dementia and known behaviors on 5/10/2021 and evaluated their status and treatment plans. Psychiatric Nurse Practitioner will follow these Resident□s weekly, as needed. Physician #1 was verbally educated on the necessity of Psychiatric Services for patients with known behaviors by Administrator on 5/25/2021. Patients with behaviors were reviewed on 5/6/2021 by the Social Services Director to ensure appropriate interventions for behaviors were in place. This was ongoing until completed on 5/26/21. On 5/7/21, the Psychiatric Nurse Practitioner assessed residents for psychosocial concerns in relation to the aggressive behaviors of Resident #1, as well as those residents with documented	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 740}	Continued From page 160	{F 740}		

ongoing
The facility provided a Credible of Removal Plan of IJ, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit in order to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy.
The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interview, resident interview, family interview, record review, in-service review, and observation. The facility provided evidence the facility had implemented corrective actions listed in the Credible Allegation of Removal Plan of IJ. The IJ was determined to be removed on 6/12/21.
Upon validation, the IJ for 42 CFR 483.40 has been lowered from the scope and severity of a "J" to the scope and severity of a "D".
The facility will remain out of compliance at Scope and Severity of "D" that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.
Findings include:

The facility's, "Behavioral Health Services" policy, undated, noted, it is the policy of the facility to provide all residents the necessary behavioral health care and services to assist him or her to reach and maintain the highest practicable level of physical, mental, and psychosocial functioning

behaviors. No new orders were given. Beginning 5/6/21 all residents were evaluated for behaviors by the Nurse Management Team (Director of Nursing, Minimum Data Set, Assistant Director of Nursing/Infection Control Coordinator, Medical Records) and a comprehensive plan of care was completed for each resident.
2. All residents with behaviors have the potential to be affected by the deficit practice cited.
3. Beginning 5/6/21, the Senior Director of Operation, Administrator and/or Assistant Director of Nursing/Infection Control Coordinator conducted multiple mandatory in-services with all nurses (Registered Nurse, Licensed Practical Nurse, Certified Nurse Aides) and facility employees including regarding behavioral health care, aggressive behaviors, symptoms of acute mental status change, acute behavior changes, and behavior assessment plan and forms. These in-services were either in-person, in a classroom setting, or 1:1, either in person or by telephone. Any staff missing in-services will not work until they receive the education. Any staff who fail to comply with the directions of the in-services will be further educated and/or progressive discipline will begin as indicated. No staff will be allowed to work until mandatory in-services are completed. Beginning on 05/20/21 and completed on 05/23/21, Human Resources initiated for all staff the six modules of Hand in Hand training that include four modules on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 740}	Continued From page 161 in accordance with the comprehensive assessment and plan of care. This policy noted behavioral health care plans will be reviewed and revised as needed, such as when interventions are not effective or when the resident experiences a change in condition. A review of the facility's last Dementia training, dated January 21, 2020, revealed the facility had conducted a virtual training with the facility staff. Resident #1 A review of Resident #1 Pre-Admission Screening (PASSR) dated 3/30/21, revealed Resident #1 has a diagnosis of Alzheimer's Dementia. The PASSR revealed Resident #1 takes and has a history of taking, psychotropic medication, but the PASSR does not have a diagnosis or history of a major mental illness listed for Resident #1. A review of the facility's Comprehensive Care Plan dated 4/15/21, revealed Resident #1's care plan listed the resident "has the potential to be aggressive with staff and other residents related to anger, dementia, and poor impulse control" due to impaired cognitive function/dementia or impaired thought process related to Dementia or impaired thought processes r/t Dementia. The interventions included to engage the resident in simple, structured activities that avoid overly demanding tasks, to administer medications, analyze time of day, places, circumstances, assess, anticipate the resident's needs, triggers and what de-escalates behavior, to cue, reorient and supervise as needed. Resident #1 also has Activities of Daily Living (ADL) self-care performance deficit related to aggressive behavior and confusion.	{F 740}	Dementia/Behaviors and two modules on abuse and neglect. Direct care staff were in-serviced by the Social Services Director and Life Connections Coordinator on 5/24/2021 to include behavior management techniques, notifying the interdisciplinary team of behavior concerns, providing safety for residents in the event of behaviors, and de-escalation techniques. On 5/28/21, Second Wind Dreams completed virtual dementia training with all nursing staff. Beginning on 5/29/21 and completed on 6/01/21 the Director of Operations reviewed the facility□s behavior management program policy for needed updates with no recommendations for change. The Psychiatric Nurse Practitioner will continue to monitor those residents for potential psychosocial concerns in relation to Resident #1, and to monitor residents with documented behaviors and those residents receiving psychoactive meds. 4. The Director of Social Services for the management company, facility Social Services or Life Connections Coordinator will review progress notes for new behaviors daily times three months beginning 6/21/21. Three residents will be selected to ensure appropriate interventions and updated care plans weekly times four weeks beginning 6/21/21 and monthly times three months beginning 7/21/21. Findings will be brought to QAPI monthly beginning 7/2/21 for review, revision, or resolution of the plan for six months. Independent monitoring began 6/7/21 by an outside	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 740}	Continued From page 162 A review of the previous facility's progress notes dated 3/8/21 revealed Resident #1 exhibited behaviors prior to admission. Resident #1 continues to wander, requires constant monitoring and redirection by staff, sometimes resident is verbally aggressive with staff and residents, spits on the floor and going in and out of other residents' rooms. A review of the facility's Nurses' Notes dated 4/20/21 at 11:06 AM, revealed Registered Nurse (RN) #2 over heard Resident #6 say "don't touch my hair." The note revealed RN #2 got up from the nurse's station to see what was going on. RN #2 heard Resident #1 say "I'm going to kill your God D**n A**." Resident #1 repeated that two more times. Observation 5/4/21 at 1:14 PM, revealed Resident #1 pacing up and down the facility hallway screaming and cursing loud with balled fist. Resident #1 did not have on shoes or mask. The facility Administrator attempted to redirect the resident and was unsuccessful. Resident #1 approached the State Agency (SA) and poked her in the chest. The resident was redirected by the staff down hallway. On 05/5/2021 at 2:00 PM, in an interview with Resident #6, revealed she is afraid of Resident #1. Resident #6 said Resident #1 pulled her hair and hit her. Resident #6 said Resident #1 yells and screams at the other residents and staff all day. During an interview on 05/5/21 at 1:15 pm, with the Director of Nurses (DON) revealed she do not have any behavioral health training. The DON	{F 740}	consulting firm is being performed for compliance assistance. The Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 740}	Continued From page 163	{F 740}		

said she was not part of the admission process when Resident #1 was admitted to the facility. The DON said the residents and the staff are afraid of Resident #1. The DON confirmed the staff has not had any behavioral health training. The DON said Resident #1 is a danger to himself and others. The DON said the staff told her Resident #1 pulled Resident #6's hair and verbally threatened her. The Doctor wrote orders to send him to the local Behavioral Unit.

A review of the local Behavioral Health notes dated 4/20/21, revealed Resident #1 was admitted 4/20/21 due to aggressive behaviors. Resident #1 presented with psychosis, hallucinations, and aggressive behaviors toward other Residents at the nursing home. Resident #1 continues to pace in the hallways at the nursing home. Resident continued to present with aggression/threatening behavior, medication was given to stabilize him.

A Review of the local Behavioral Health Discharge Summary dated 4/29/21, revealed Resident #1 was discharged with a new prescription to give Seroquel 25 mg by mouth (po) twice a day for psychosis. The order also states to continue Buspirone 10 mg po twice a day for mood disorder, Zyprexa 10 mg every eight hours as needed for psychosis, Seroquel 300 mg po at bedtime for psychosis, divalproex SOD DR 250 mg po twice a day for seizures and Alprazolam 0.5 mg for anxiety.

A review of the facility's physician's orders revealed Seroquel 25 mg orally twice a day was discontinued on 5/1/21 by the facility Medical Doctor (MD).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 740}	Continued From page 164	{F 740}		

Interview with the facility's Medical Doctor on 5/20/21 at 12:30 PM, revealed she discontinued the Seroquel 25 mg orally twice a day because of the black box warning.

On 05/5/21 at 10:00 AM, interview with the Social Services Director (SSD) said in a meeting with the Administrator, Assistant Director of Nursing (ADON) and Admissions Director discussed Resident #1's behavior. The SSD said the facility cannot meet Resident #1's needs. She stated Resident #1 has too many behaviors and cannot be redirected. The SSD also suggested to send Resident #1 to the behavior unit prior to him hitting Resident #6. The SSD confirmed Resident #1's PASSR is not correct.

On 5/5/22 at 10:15 AM, with (RN) #3 said she was sitting at the nurse station on the Alzheimer's Unit (AD) and heard Resident #6 say "do not touch my hair again". The nurse said she did not see Resident #1 hit Resident #6. The nurse said by the time she got down the hall Resident #1 was yelling and threatening Resident #6. Resident #1 said I am going to kill you, "B****." The nurse said she separated the residents. RN #3 said she has asked the DON and the Administrator several times to send Resident #1 out. The nurse said Resident #1 is dangerous and she is afraid he is going to hurt one of the residents or the staff. RN #3 said Resident #1 is hard to redirect.

On 5/5/21/21 at 10:30AM, in an interview with RN #4, she said she works on the AD unit from 7PM-7AM. RN #4 said Resident #1 was hard to redirect. RN #4 also said Resident #4 curses and yells at the residents constantly. RN #4 said she told the MD that she was concerned Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 740}	Continued From page 165	{F 740}		

might hurt one of the vulnerable residents on the unit. RN #4 said the other residents are scared to death of him.

On 5/5/21 at 10:45 AM, in an interview with The Activity Coordinator (AC) for the AD unit said she was responsible for doing Dementia training with the staff. The (AC) said the staff is trained on hire and annually. The AC said the staff has not been trained in over a year since the pandemic began. The facility has hired several new staff that has not been trained on Dementia care. The AC said when Resident #1 was on the AD unit she had to do one on one activities with him because his attention span was short. The AC coordinator said he was hard to redirect. He would yell and scream at the other residents.

An interview on 5/5/21 at 11:30 AM, with CNA # #7 said he works the 7-3 shift. CNA #7 said Resident #1 is hard to redirect. CNA #7 said Resident #1 fights the staff when they attempt to provide care. CNA #7 confirmed he has not had any behavior training on how to take care of residents with those type of behaviors. The resident is frightening and intimidates the other residents.

During an interview on 5/5/21 at 1:30 PM, with the Psych Nurse Practitioner (NP) revealed she has not been in the facility since March 2020. The Psych (NP) said the facility refused to allow her to come in the facility due to Covid-19. The facility called her and asked her to come back to the facility on 05/5/21. The Psych (NP) said she will assess and monitor the residents on the AD and the residents that have behaviors. The Psych (NP) said she monitors the residents' medications. The Psych (NP) said she will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 740}	Continued From page 166	{F 740}		

visiting the residents twice a week. The Psych (NP) said she will review all Residents that is on psychotropic medications at that time.

On 5/11/21 at 4:35 PM, in an interview with License Practical Nurse (LPN) #14, revealed she worked the AD unit with Resident #1. LPN #4 said Resident #1 cursed the staff and other residents all the time. LPN #14 said Resident #1 continued to call them "B*****s and M****r F*****s" the whole shift. LPN #14 also said Resident #1 is hard to redirect and is impulsive. He runs up to the other resident's faces and draws his fist, yells, and curses at them. LPN #14 confirmed she has not had any behavior or dementia training. LPN #14 said she did not know what to do for Resident #1. LPN #14 said she reported to the DON and the Administrator that the staff did not know what to do to take care of Resident #1 and that he was a danger to himself and the other residents. LPN #14 said she was told to call the doctor and report his behavior. LPN #14 said she was calling the doctor every hour and the doctor finally said do not call her again, call the Administrator because he refuses to send the resident to a behavioral health unit. LPN #14 said the Administrator said he could not send the resident out because his census was low, and he had to keep every resident he could in the building. LPN #14 said she told the Administrator that it is not right that the facility will not get this man some help and cause the other residents to be in fear in their home. LPN #14 said this is the most horrible place, "I've ever worked."

Record review of the Face Sheet revealed the facility admitted Resident #1 on 3/17/2021, per the face sheet, with the diagnoses that included Dementia with Behavioral disturbance, Epilepsy,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 740}	Continued From page 167 Mood disorder and Psychosis. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/26/21, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) of 00 indicating Resident #1 is cognitively severely impaired. Removal Plan: Resident #6 was evaluated by the Social Services Director on 4/20/2021 for any psychosocial needs and evaluated again by the Psychiatric Nurse Practitioner on 5/07/21. The resident received Pastoral Consultation on 5/25/21. Resident #1 was sent out and admitted to behavioral health on 4/21 and again on 5/4/21. The resident was discharged to behavioral health on 05/07/21. Beginning 5/6/21, the Senior Director of Operation, Administrator and/or ADON/ICC conducted multiple mandatory in-services with all nurses (RN, LPN, CNAs) and facility employees including regarding behavioral health care, aggressive behaviors, symptoms of acute mental status change, acute behavior changes, and behavior assessment plan and forms. These in-services were either in-person, in a classroom setting, or 1:1, either in person or by telephone. Any staff missing in-services will not work until they receive the education. Any staff who fail to comply with the directions of the in-services will be further educated and/or progressive discipline will begin as indicated. No staff will be allowed to work until mandatory in-services are completed. The Psychiatric Nurse Practitioner visited residents with dementia and known behaviors on 5/10/2021 and evaluated their status and treatment plans. Psychiatric Nurse Practitioner will follow these Resident's weekly, as needed. Beginning on 05/20/21 and completed on	{F 740}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 740}	Continued From page 168	{F 740}		

05/23/21, Human Resources initiated for all staff the six modules of Hand in Hand training that include four modules on Dementia/Behaviors and two modules on abuse and neglect.
Direct care staff were in-serviced by the Social Services Director and Life Connections Coordinator on 5/24/2021 to include behavior management techniques, notifying the interdisciplinary team of behavior concerns, providing safety for residents in the event of behaviors, and de-escalation techniques.
Physician #1 was verbally educated on the necessity of Psychiatric Services for patients with known behaviors by Administrator on 5/25/2021.
On 5/28/21, Second Wind Dreams completed virtual dementia training with all nursing staff.
Patients with behaviors were reviewed on 5/6/2021 by the Social Services Director to ensure appropriate interventions for behaviors were in place.
Beginning 5/6/21 all residents were evaluated for behaviors by the Nurse Management Team (DON, MDS, ADON/ICC, Medical Records) and a comprehensive plan of care was completed for each resident. This was ongoing until completed on 5/26/21.
On 5/7/21, the Psychiatric Nurse Practitioner assessed residents for psychosocial concerns in relation to the aggressive behaviors of Resident #1, as well as those residents with documented behaviors. No new orders were given. The Psychiatric Nurse Practitioner will continue to monitor those residents for potential psychosocial concerns in relation to Resident #1, and to monitor residents with documented. behaviors and those residents receiving psychoactive meds.
Validation:

The State Survey Agency (SSA) validated through

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 740}	Continued From page 169	{F 740}		

review of the facility Progress notes Resident #6 was evaluated by the social services director on 4/20/21 for psychosocial needs and evaluated by the Psych NP on 5/7/21 Resident #6 received a pastoral consultation on 5/25/21.
The SSA validated through review of the facility progress notes Resident #1 was discharged from facility to behavioral health facility on 5/7/21.
The SSA validated through staff interviews and review of in-service sign in sheets, the Senior Director of Operations, Administrator, and ADON/ICC conducted multiple mandatory in-services with all nursing disciplines (RN, LPN, CNA's) and facility employees including regarding behavioral health care, aggressive behaviors, symptom of acute behavior changes, and behavior assessment plans and forms. Any staff who failed to comply with the directions of in-services will be further educated and or progressive discipline will begin as indicated. No staff will be allowed to work until mandatory in-services are completed. The ADON verified no staff had worked until they received in-services and there have been no staff who have failed to comply with the directions of the in-services.
The SSA validated through interviews and review of Progress notes the psychiatric NP assessed residents with dementia and known behaviors on 5/10/21 and evaluated their status and treatment plans. The psych NP will follow these resident's weekly as needed.
The SSA validated through interviews and review of the facility in-service sign in sheets, on 5/20/21 and completed on 5/23/21, Human resources initiated for all staff the six modules of hand training that include four modules on Dementia/ behaviors and two modules on abuse and neglect.
The SSSA validated through staff interviews and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 740}	Continued From page 170 review of in- service sign in sheets, the Social Services Director (SSD) and Life Connections Coordinator conducted in-services regarding behavior management techniques, notifying the interdisciplinary team of behavior concerns, providing safety for residents in the event of behaviors, and de-escalation techniques. The SSA validated through interviews and record review Physician #1 was verbally educated on the necessity of psychiatric services for patients with known behaviors by the Administrator on 5/25/21. The SSA validated through review of facility in-service sign in sheets, virtual dementia training with all nursing staff was conducted by a contracted training provider on 5/28/21. The SSA validated through interviews and review of the Comprehensive Care Plans and progress notes, the SSD reviewed the care plan interventions for residents with behaviors and made changes as needed. The SSA validated through interviews and review of the progress notes all residents were reviewed by the nurse management team (DON, MDS, ADON/ICC Medical Record) and care plans were completed for each resident. The SSA validated through interviews and review of progress notes and the facility policy on 5/7/21 the psychiatric NP assessed residents for psychosocial concerns in relation to the aggressive behaviors of Resident #1 as well as those with documented behaviors. The consultant reviewed the behavior management program policy with no needed changes on 6/1/21.	{F 740}		
{F 741} SS=E	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the	{F 741}		7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 741}	Continued From page 171 appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and record review, the facility failed to provide sufficient/competent staff for Behavioral Health needs when Resident #6 was assaulted and hair pulled by Resident #1 and Resident #9 had his chest rammed by Resident #1, for one (1) of five (5) Residents reviewed for behaviors. Resident #1. The facility's failure to provide sufficient /competent staff for Behavioral Health needs and	{F 741}	1. Resident #1□s incidents have been thoroughly investigated by the Interdisciplinary Team and recommendations have been stated. Resident #1 was admitted to behavioral health on 4/21/21, transferred and admitted again to behavioral health on 5/4/21. On 5/07/21 the resident was discharged from the facility. Resident #6 was evaluated by the Social Services Director on 5/06/2021 for any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 741}	Continued From page 172 address known behaviors put Resident #6, Resident #9 and all the residents who reside in the facility at risk for serious harm, serious injury, serious impairment, or possible death. This situation was determined to be an Immediate Jeopardy (IJ), which began on 3/17/21 and determined to exist on 4/20/21 when Resident #1 assaulted Resident #6, rammed his chest into Resident #9's chest and caused other residents to be afraid to live in the facility. The IJ and Substandard Quality of Care (SQC) existed at CFR(S): 483.40(a)(1)(2)- Behavioral Health Services The IJ was not removed prior to exit on 05/26/21 and was considered ongoing. The facility provided a Credible Removal Plan of IJ, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit in order to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interview, resident interview, family interview, record review, in-service review, and observation. The facility provided evidence the facility had implemented corrective actions listed in the Credible Allegation of Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for 42 CFR 483.40(a)(1)(2) has been lowered from the scope and severity of a "K" to the scope and severity of an "E".	{F 741}	psychosocial needs and evaluated again by the Psychiatric Nurse Practitioner on 5/07/21. The resident received Pastoral Consultation on 5/25/21. Resident #9 was evaluated by the Social Services Director after his encounter with Resident #1 and received pastoral Consultation on 5/25/21. All Residents with behaviors were reviewed on 5/6/2021 by the Social Services Director to ensure appropriate interventions for behaviors were in place. 2. All resident with behavioral health needs have the potential to be affected by the deficit practice cited. 3. Effective 6/05/21 the Social Services Director or Life Connections Coordinator serves as the Facility□s contact person for questions regarding behavioral services provided by the facility and outside resources such as physicians, psychiatrists, or neurologists. Beginning 5/8/21 and again 5/23/21 the Administrator and Regional Director of Operations conducted multiple mandatory in-services with all staff regarding behavioral health care, aggressive behaviors, symptoms of acute mental status change, acute behavior changes, and behavior assessment plan and forms. These in-services were either in-person, in a classroom setting, or 1:1, wither in person or by telephone. Any staff missing in-services will not work until they receive the education. Any staff who fail to comply with the directions of the in-services will be further educated and/or progressive discipline will begin as indicated. No staff will be allowed to work until mandatory in-services are completed. Beginning on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 741}	Continued From page 173 The facility will remain out of compliance at Scope and Severity of "E" that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Record review of the facility's, "Behavioral Health Services" policy, undated revealed, "It is the policy of the facility to provide all residents the necessary behavioral health care and services to assist him or her to reach and maintain the highest practicable level of physical, mental, and psychosocial functioning in accordance with the comprehensive assessment and plan of care ... behavioral health care plans will be reviewed and revised as needed, such as when interventions are not effective or when the resident experiences a change in condition ..." The facility's, "Staffing" policy, dated 6/1/00, noted it is the policy of the facility to provide adequate staffing to meet the needs of the resident population. On 5/4/21 at 1:14 PM, observed Resident #1 pacing up and down the facility hallway screaming and cursing loud with his balled fist. Resident #1 did not have on shoes or a mask. The facility Administrator attempted to redirect Resident #1 and was unsuccessful. Resident #1 approached the State Agency (SA) poking her in the chest. The resident was redirected by the staff down hallway.	{F 741}	5/20/21 and completed 5/23/21 Human Resources initiated for all staff the six modules of Hand in Hand training that include four modules on Dementia/Behaviors and two modules on abuse and neglect. Direct care staff were in-serviced by the Social Services Director and Life Connections Coordinator on 5/24/21 to include behavior management techniques, notifying the interdisciplinary team of behavior concerns, providing safety for residents in the event of behaviors, and de-escalation techniques. On 5/28/21, Second Wind Dreams completed virtual dementia training with nursing staff. Beginning 5/28/21 the Assistant Director of Nursing and other nursing managers began evaluating staff competencies that are necessary to provide the level and types of care needed for the resident population with identified behaviors. On 6/1/21, the Independent Consultant and the Director of Operations reviewed the Competencies for behavior care with no recommendations suggested. 4. Assistant Director of Nursing or Director of Nursing will monitor staff competency for completeness bi-monthly beginning 7/2/21. The Director of Social Services for the management company, facility Social Services or Life Connections Coordinator will review progress notes for new behaviors daily times three months beginning 6/21/21. Three residents will be selected to ensure appropriate interventions and updated care plans weekly times four weeks beginning 6/21/21 and monthly times three months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 741}	Continued From page 174 On 5/5/21 at 10:45 AM, in an interview with The Activity Coordinator (AC) for the AD unit said she was responsible for doing Dementia training with the staff. The (AC) said the staff is trained on hire and annually. The AC said the staff has not been trained in over a year since the pandemic began. The facility has hired several new staff that has not been trained on Dementia care. On 5/5/21 at 11:30 AM, an interview with CNA # #7 said he works the 7-3 shift. CNA #7 confirmed he has not had any behavior training on how to take care of residents with those type of behaviors. The resident is frightening and intimidates the other residents. On 5/5/21 at 11:45AM, an interview with the Social Services Director (SSD), the SSD said that after Resident #1 was admitted the resident immediately started yelling, cursing, and swinging at the residents. The SSD said she told the Administrator and the DON that Resident #1 is dangerous and can cause harm to the vulnerable residents and the resident refuses to be re-directed. The SSD said she told the Administrator the resident needs to be sent out before he hurts somebody. The SSD confirmed the staff does not have behavioral training. During an interview on 05/5/21 at 1:15 PM, with the Director of Nursing (DON), revealed she did not talk to Resident #6 about Resident #1 hitting her. The DON confirmed the staff is not trained to take care of residents with behaviors. The DON said she told the Administrator that this facility cannot meet the needs of Resident #1. The DON also stated Resident #1 is a danger to himself and others.	{F 741}	beginning 7/21/21. Findings will be brought to Quality Assurance Performance Improvement monthly beginning 7/2/21 for review, revision, or resolution of the plan for six months. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance. The Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 741}	Continued From page 175	{F 741}		

During an interview on 05/5/21 at 1:30 PM, with the Administrator revealed he knew Resident #1 had behaviors. The Administrator also confirmed the staff has not been trained in behavioral health. The Administrator said the facility had a Psychiatric Nurse Practitioner (NP) that monitors and adjusts the medications for residents with behaviors. The Psychiatric (NP) has not seen the residents since March 2020. The Administrator said the psychiatric (NP) will start back working for this facility 5/5/21 to educate staff, monitor and adjust the residents' medications with behaviors. The Administrator also confirmed the Facility Assessment is not sufficient to guide the staff to meet the needs of the Residents.

On 05/5/2021 at 2:00 PM, in an interview with Resident #6 revealed she is afraid of Resident #1. Resident #6 said Resident #1 hit her and pulled her hair. Resident #6 said Resident #1 continues to yell and scream at her and the other residents. Resident #6 said if Resident #1 comes up to her again she is going to punch him before he can get to her because she is afraid of him.

Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/26/21, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 13, that indicated that Resident #6 is cognitively intact.

On 05/6/2021 at 11:00 AM, interview with Resident #9 said Resident #1 ran up to him and rammed his chest into his chest. Resident #9 said Resident #1 also hit him. Resident #9 said if Resident #1 comes at him again he is going to knock him out because that man is "crazy." Resident #9 said he told the staff Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 741}	Continued From page 176	{F 741}		

needs to go to a psychiatric hospital because he is going to hurt somebody. Resident #9 said Resident #1 fights the staff all the time and yells and scream at the residents. everybody is afraid of him. "I'm going to hit him before he hit me." Record review of the Quarterly MDS with an ARD of 4/18/21, revealed Resident #9 had a BIMS score of 15 indicating cognitively intact.

On 5/11/21 at 4:35 PM, in an interview with (LPN) #14 revealed LPN #14 said the staff has not had any behavior or dementia training. LPN #14 also said she does not know what to do for this resident. LPN #14 said she reported to the DON and the Administrator that the staff did not know what to do to take care of Resident #1 and that he was a danger to himself and the other residents. LPN #14 said she told the Administrator that this is not right. The facility should get Resident #1 some help because the other residents are in fear in their home.

Record review of the facility's last Dementia training dated 1/21/20 revealed the facility had a virtual dementia training with the facility staff.
Removal Plan:
The deficient practice consisted of the facility failed to provide sufficient/competent staff for Behavioral Health needs when Resident #6 was assaulted, and hair pulled by Resident #9 had his chest rammed by Resident #1. Noncompliance at F741 impacted Residents: #1, #6, and #9. Resident #1's incidents have been thoroughly investigated by the Interdisciplinary Team and recommendations have been stated. Resident #1 was admitted to behavioral health on 4/21/21, transferred and admitted again to behavioral health on 5/4/21. On 5/07/21 the resident was discharged from the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 741}	Continued From page 177 Resident #6 was evaluated by the Social Services Director on 5/06/2021 for any psychosocial needs and evaluated again by the Psychiatric Nurse Practitioner on 5/07/21. The resident received Pastoral Consultation on 5/25/21. Resident #9 was evaluated by the Social Services Director after his encounter with Resident #1 and received pastoral Consultation on 5/25/21. All Residents with behaviors were reviewed on 5/6/2021 by the Social Services Director to ensure appropriate interventions for behaviors were in place. Validation: The State Survey Agency (SSA) validated through interviews and review of the facility's progress notes Resident #1's incidents have been thoroughly investigated by the interdisciplinary team and recommendations have been stated. Resident #1 was admitted to behavioral health on 4/21/21, transferred and admitted again to behavioral health on 5/4/21. On 5/7/21 the resident was discharged from the facility. The SSA validated through review of the facility's progress notes Resident #6 was evaluated by the social services Director on 5/6/21 for any psychosocial needs and evaluated again by the psychiatric Nurse Practitioner on 5/7/21. The resident received pastoral consultation on 5/25/21. The SSA validated through review of the facility's progress notes Resident #9 was evaluated by the social services director after his encounter with Resident #1 and received pastoral consultation on 5/25/21. The SSA validated through review of the facility's progress notes all residents with behaviors were reviewed on 5/6/21 by the social service director to ensure appropriate interventions for behaviors were in place.	{F 741}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 755} SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, facility policy review and record review the facility failed to ensure that routine medications were acquired and administered to	{F 755}	1. The Assistant Director of Nursing/Infection Control Coordinator was in-serviced regarding the process for obtaining medications from the pharmacy,	7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 755}	Continued From page 179 meet the needs of the residents. Facility documentation indicated that 12 of the 17 residents had missed 393 doses of significant medications. (Resident #1, #2, #4, #7, #8, #9, #10, #11, #12, #15, #16, and #17) The Facility's failure to provide routine medications placed residents at risk, and in a situation that resulted in hospitalization of Resident #4 and likely resulted in the death of Resident #12 who expired in the facility after missing 37 doses of significant medications. Missing significant medications is likely to cause serious harm, injury, impairment of death to all residents residing in the Facility. This situation was determined to be an Immediate Jeopardy (IJ) which began on 11/17/2020, when Resident #4 missed 26 doses of medications ordered for COVID-19, was hospitalized on 11/29/2020 and subsequently died at home. There were also eleven (11) other residents who missed significant medication doses. The facility Administrator was notified of the IJ on 5/21/2021 and the IJ template was given to the Administrator at 3:30 PM. The IJ and Substandard Quality of Care (SQC) existed at CFR(S): 483.55(a)- Pharmaceutical Procedures. The IJ was not removed prior to the State Agency (SA) exit on 5/26/2021 and was considered ongoing. The facility provided a Credible Removal Plan, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit	{F 755}	including the back-up pharmacy process, on 5/22/2021 by the Regional Nurse Consultant. The ADON initiated education regarding obtaining medications from the pharmacy, the back-up pharmacy process, and completing match backs daily for all nurses on 5/22/2021. The attending physician was notified of the missed medications on 5/25/2021 by Medical Records with no new orders at that time. On 6/01/21, the Owner sent a letter of termination of services for the current Pharmacy Service and a new company will take over in 30 days. There will be no lapse in pharmacy services for the residents. 2. All residents receiving medications have the potential to be affected by the deficit practice cited. 3. Medical Records Manager, the Assistant Director of Nursing, and the Director of Nursing completed a match back on 5/21/21 on all medication carts to ensure that all medications were available as ordered. Any medication notes as unavailable were ordered from the pharmacy and were obtained. Resident #8 medications on 05/05/21. Resident #4 discharged 11/29/20. Resident #1 discharged on 5/4/21. Resident #2 medications were ordered on 3/1/21, 3/8/21, 3/18/21, 4/8/21. Resident #7 medications were ordered 3/28/21, 04/13/21. Resident #9 medications were ordered on 2/25/21. Resident #10 medications were ordered on 3/16/21 and 4/2/21. Resident #11 medications were ordered on 2/17/21. Resident #12 medications were ordered on 4/6/21,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 180 to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interviews and in-service sign-in sheets review. The facility provided evidence the facility had implemented corrective actions listed in the Credible Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for 42 CFR 483.45(f)(2) has been lowered from the scope and severity of a "K" to the scope and severity of an "E". The facility will remain out of compliance at Scope and Severity of "E" that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the Facility's policy entitled "Pharmaceutical Services", dated February 26, 2003, reveals that it is the policy of the Facility to provide all drugs and biologicals an approved pharmaceutical service and such services are under the supervision of a Registered Pharmacist. The Procedure states: "1. Pharmaceutical services are available to ensure that our resident's drugs and biologicals are provided as ordered by the attending physician ... 3. Our pharmaceutical services provide appropriate methods and procedures for the procurement, dispensing and administration of	{F 755}	4/12/21, and 5/6/21. Resident # 15 medications were ordered on 3/9/21, 3/18/21, 4/6/21. Resident #16 medications were ordered on 2/26/21, 4/16/21, 4/26/21, 5/2/21, 5/6/21. Resident #17 medications were ordered on 3/4/21, 3/10/21, 4/8/21, 4/12/21, and 5/1/21. Daily medication match backs were initiated on 5/21/21 by the medication nurses. 4. DON or ADON will utilize the medication audit tool to monitor non-administered medication weekly times four weeks beginning 7/1/21 and then monthly beginning 8/2/21 time three months. New orders and non-administered meds are reviewed daily in clinical standup beginning the week of 7/1/21. Findings will be brought to Quality Assurance Performance Improvement monthly beginning 7/2/21 for review, revision, or resolution of the plan for six months. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance. The administrator will report to the Governing Body and the Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 755}	Continued From page 181	{F 755}		

drugs and biologicals.
4. Pharmacy service, including the availability of obtaining prescription drugs, is provided on a twenty-four (24) hour basis.
5. Pharmacy services are monitored to assure that our drug distribution system, to include the ordering, labeling, and administering of drugs and biologicals, is in compliance with out established policies and procedures ....."

Review of the facility's policy entitled "AmPharm Backup Information", undated, revealed: ..... "2. The facility can get up to 3 days of medications to cover until our shipment reached the facility. Getting more than a 3-day supply is not authorized. 3. If medications are needed for a patient during our hours of operation, the facility is to contact AmPharm, and we will take care of the backup process. 4. If medications are needed for a patient during hours that AmPharm is closed, the facility is to contact the after-hours pharmacy and they will take care of getting the medications filled and delivered to the facility. The facilities are not authorized to contact backup directly for medication fills. They are to contact AmPharm or the after-hours pharmacy. This is to keep costs down and to have a record of medications we need to send without duplicating items."

On 5/5/21 at 9:10 AM, in an observation and interview of medication pass with Licensed Practical Nurse (LPN) #6, two (2) medications were unavailable for administration. Resident #8 did not receive Jardiance 25 MG ordered for Diabetes and Topiramate 25 milligrams (MG) ordered for the prevention of headaches. LPN #6 entered a number "9" in the signature box and stated the nurses record that number in the resident's record to identify that the medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 182	{F 755}		

were not administered because they are unavailable. She further stated that there is no back up pharmacy and that the facility has an emergency kit for medications, but it contains mostly antibiotics.

On 5/6/2021 at 8:10 AM, an interview with LPN #5, she stated that medications are not always available on the medication cart, as they are on order.

On 5/6/21 at 10:45 AM, in an interview with the Director of Nurses (DON), she explained that the Facility uses a Local Pharmacy (LP) for back up. She stated that if medications are needed, the nurses must contact the Facility's Pharmacy (FP) and they contact the back-up pharmacy. She stated that Human Resources provides orientation to newly hired nurses on ordering medications.

On 5/6/2021 at 2:30 PM, an interview with LPN #9, she stated that she has worked at the facility for three (3) months. She stated the facility only uses the FP, but they used to use the LP for back-up meds.

On 5/6/2021 at 3:55 PM, in an interview with the Medical Nurse Practitioner (MNP), she stated that residents have told her they have not been receiving their medications. When residents have complained, she would question the nurses about the medications, and they would tell her that the medications were on order.

On 5/8/2021 at 12:20 PM, in an interview with LPN #7, she stated that she has worked at the facility for two (2) months. LPN #7 revealed that back up pharmacy has not been used by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 183	{F 755}		

facility since March 2021. She further stated that Eliquis is not a cycle medication and must be reordered every time, causing a problem with getting that medication in a timely manner.

On 5/8/2021 at 1:20 PM, in an interview with LPN #8, she revealed that she has worked at the facility for five (5) years. She stated during this time, there has not been any training on ordering or reordering medications.

On 5/20/21 at 9:15 AM, in an interview with the (DON) she stated that she was aware that the nurses were unable to get medications. The DON said she had told the nurses to document everything in the resident charts, because she had told the Administrator that the medications were not coming in and she did not know what else to do.

On 5/20/21 at 10:15 AM, in an interview with the Nurse Consultant, she stated she had spoken to the DON and had recommended the DON to do in-services for the nurses on the appropriate way to obtain medications. She stated that the DON did not follow up with the in-services.

On 5/20/21 at 12:30 PM, in an interview with the Medical Doctor #2 (MD #2), she stated that she is aware that residents do not get their medications in a timely manner and there are times when residents have been without medications for days. She stated most of the time she is not notified for several days of residents not receiving their medications. The MD explained that when she has questioned the nurses regarding medications not being given, they would tell her the medications are on order. The MD said that she has met with the Administrator and DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 184	{F 755}		

regarding her concerns.

On 5/20/21 at 1:00 PM, in a telephone interview with the Medical Director, he revealed that he was aware of medications not being available, but he thought the problem had been corrected. The Medical Director stated that he should have known about the deficient issues within the Facility and followed up. He stated that the Quality Assurance and Performance Improvement (QAPI) Committee should have kept him informed.

On 5/20/21 at 2:00 PM, in an interview with the Administrator, he confirmed that he is aware that the Facility has a system failure with medication administration. He stated in April's QAPI meeting they discussed medications not being given. He further stated that the DON is supposed to call the pharmacy when a medication is not available.

On 5/20/21 at 2:30 PM, in a telephone interview with the Owner of the Facility, he stated that he was aware of the medication issues within the Facility. He said, "but I did not know how severe it was." He stated that the QAPI program had failed.

Resident #4

Record review Resident #4's Admission Record revealed the resident was admitted to the Facility on 8/15/2017 and readmitted on 10/27/2020.

Record review of Resident #4's Diagnosis Information included COVID-19, Heart Failure, Type 2 Diabetes Mellitus, Recurrent Major Depressive Disorder, Acute Kidney Failure, Chronic Obstructive Pulmonary Disease, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 185 Anxiety Disorder. Record review of the Admission Minimum Data Set (MDS) dated 11/1/2020 revealed that Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicates that Resident #4 was cognitively intact. On 11/17/2020, Resident #4 tested positive for COVID-19 and the Physician ordered the following medications: 1. Azithromycin Tablet 250 Give 500 milligrams (MG) by mouth one time a day for infection for one (1) day 2. Dexamethasone Tablet 6 MG Give 1 tablet by mouth one time a day for COVID-19 for 10 days 3. Zinc Sulfate Capsule 20 Mg Give 1 capsule by mouth two times a day for COVID-19 4. Famotidine Tablet 40 MG Give 2 tablets by mouth three times a day for COVID-19 for 30 days Review of Resident #4's Medication Administration Record (MAR) revealed that the resident did not receive the following dose(s) of medications because they were unavailable: -Azithromycin 500 mg - 11/18/20 (1 of 1 dose missed) -Dexamethasone - 11/18/2020, 11/20/2020 and 11/25/2020 (Three (3) missed doses) -Famotidine - 11/17/2020, 11/18/2020, 11/22/2020, 11/23/2020, 11/24/2020, 11/25/2020, and 11/27/2020 (Nine (9) missed doses) -Zinc - 11/17/2020, 11/18/2020, 11/19/2020, 11/20/2020, 11/22/2020, 11/23/2020, 11/24/2020, 11/25/2020 (13 missed doses) Resident #4 missed a total of 26 doses of significant medication ordered for COVID-19 from November 17 to November 27, 2020.	{F 755}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 186	{F 755}		

Resident #4 was transferred to the hospital Emergency Room for evaluation on 11/29/2020 and subsequently died.

On 05/04/2021 at 01:00 PM, in a telephone interview with Resident #4's mother, she revealed Resident #4 contracted COVID-19 at the facility and was transferred to the hospital. She stated she went to the hospital and her daughter's doctor told her there was nothing more that could be done for her daughter. She stated the doctor said that he did not know what had happened, but maybe she had missed medications. The resident's mother decided to take her daughter home rather than her being discharged back to the facility. She said her daughter expired on 12/22/2020.

Resident #12

Record review of the Admission Record revealed Resident #12 was initially admitted to the facility on 10/24/2020 and readmitted on 1/6/2021.

Record review of Resident #12's Diagnosis Information included Unspecified Atrial Fibrillation, Peripheral Vascular Disease, Chronic Embolism and Thrombosis of Unspecified Deep Veins of Unspecified Lower Extremity, Chronic Kidney Disease, and Essential Hypertension. Record review of the Quarterly Minimum Data Set (MDS) dated April 16, 2021, revealed that Resident #12 has a Brief Interview for Mental Status (BIMS) score of 14, which indicates that Resident #12 is cognitively intact.

Record review of Resident #12's Physician Orders revealed that the physician ordered the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 187 following medications: 1. Gabapentin Capsule 100 Grams (GM) Give 1 capsule by mouth three times a day for neuropathy (Ordered on 10/23/20) 2. Apixaban 5 mg by mouth two times a day for Deep Vein Thrombosis (Ordered 1/14/21) Review of Resident #12's MAR reveals that the resident did not receive the following dose(s) of medications because they were unavailable: -Gabapentin on 4/5/21, 4/6/21, 4/7/21, 4/8/21, 4/9/21, 4/10/21, 4/11/21, 4/12/21, 5/2/21, 5/3/21, and 5/7/21 (24 missed doses) -Apixaban on 4/13/21, 4/14/21, 4/15/21, 4/16/21, 4/17/21, 4/18/21, 4/19/21, 4/25/21, 4/26/21, 4/27/21, 5/9/21 and 5/13/21 (13 missed doses) The total number of doses of significant medications that Resident #12 missed from April 1 to May 16, 2021, totaled 37. Resident #12 was found unresponsive on May 17, 2021. Resident #12 expired at the facility. Resident #17 Record review the Admission Record revealed Resident #17 was originally admitted to the facility on 3/4/2021 and readmitted on 3/10/2021. Record review of Resident #17's Diagnosis Information revealed, Osteomyelitis of Vertebra, Sacral and Sacrococcygeal Region, Unstageable Pressure Ulcer of Sacral Region, Gram Negative Sepsis, Congestive Heart Failure, Atherosclerotic Heart Disease, Diabetes Mellitus due to Underlying Condition with Foot Ulcer, Chronic Obstructive Pulmonary Disease, Chronic Peripheral Venous Insufficiency and Essential Hypertension.	{F 755}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 188	{F 755}		

Record review of the 5-Day Minimum Data Set (MDS) dated March 12, 2021, revealed that the resident has a Brief Interview for Mental Status (BIMS) score of 15, which indicates that Resident #17 is cognitively intact.

Record Review of Resident #17's Physician Orders revealed the following Physician Orders:
1. Insulin Glargine Solution Inject 60 units subcutaneously at bedtime related to Diabetes Mellitus due to underlying condition with foot ulcer (Ordered 3/4/21)
2. Insulin Aspart Solution Inject 5 units subcutaneously three times a day related to Diabetes Mellitus due to underlying condition with foot ulcer (Ordered 3/4/21)
3. Metoprolol Tartrate Tablet 25 MG Give 1 tablet by mouth two times a day related to Essential Hypertension (3/4/21)
4. Furosemide Tablet 40 MG Give 1 tablet by mouth one time a day related to Congestive Heart Failure (Ordered 3/5/21)
5. Isosorbide Mononitrate ER Tablet 60 MG Give 1 tablet by mouth one time a day related to Atherosclerotic Heart Disease (Ordered 3/4/21)
6. Insulin Glargine Solution Inject 60 units subcutaneously in the evening related to Diabetes Mellitus due to underlying condition with foot ulcer (Ordered 3/10/21)
7. Insulin Glargine Solution 100 Init/ML Inject 15 units subcutaneously in the morning for Diabetes Mellitus due to underlying condition with foot ulcer (Ordered 3/4/21)
8. Insulin Aspart Solution Inject 5 units subcutaneously three times a day related to Diabetes Mellitus due to underlying condition with foot ulcer (Ordered 3/10/21)
9. Furosemide Tablet 20 MG Give 1 tablet by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 189 mouth one time a day related to Congestive Heart Failure (Ordered 3/10/21) 10. Clindamycin HCL Capsule 300 MG Give 1 capsule by mouth every dayshift for infection related -Gram-Negative Sepsis (Ordered 3/10/21) 11. Levofloxacin Tablet 750 MG Give 1 tablet by mouth one time a day related to Gram Negative Sepsis for 14 days (Ordered 3/10/21) 12. Cipro Tablet 500 MG Give 1 tablet by mouth every 24 hours for Osteomyelitis for 56 days (Ordered on 3/24/21) 13. Levofloxacin in D5W Solution 750 MG/150 ML Use 750 MG intravenously every 24 hours for osteomyelitis for 42 days infuse @100 ML/HR to PICC (Ordered 4/12/21) 14. Ceftriaxone Sodium Solution Reconstituted 1 GM intravenously one time a day for sacral wound infection for 14 days (Ordered 5/1/21) Review of Resident #17's MAR reveals that the resident did not receive the following dose(s) of ordered medications because they were unavailable: -Insulin Glargine Solution 60 units on 3/4/21 (One (1) missed dose) -Insulin Aspart Solution 5 units on 3/4/21 and 3/5/21 (Three (3) missed doses) -Metoprolol Tartrate 25 MG on 3/4/21 and 3/5/21 (Two (2) missed doses) -Furosemide Tablet 40 MG on 3/5/21, 3/22/21, 3/23/21, 3/29/21, 4/5/21 and 4/12/21 (Five (5) missed doses) -Isosorbide Mononitrate ER Tablet 60 MG on 3/11/21 (One (1) missed dose) -Insulin Glargine Solution Inject 60 units on 4/15/21 (One (1) missed dose) -Insulin Glargine Solution 15 units on 3/5/21 (One (1) missed dose) -Insulin Aspart Solution 5 units on 3/12/21 (One	{F 755}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 190	{F 755}		

(1) missed dose)
-Furosemide Tablet 20 MG on 3/23/21, 3/29/21 and 4/5/21 (Three (3) missed doses)
-Clindamycin HCL Capsule 300 MG on 3/11/21 and 3/12/21 (Two (2) missed doses)
-Levofloxacin Tablet 750 MG on 3/11/21 and 3/12/21 (Two (2) missed doses)
-Levofloxacin in D5W 750 MG/ML on 4/12/21 (One (1) missed dose)
-Cipro Tablet 500 MG on 4/8/21, 4/9/21 and 4/10/21 (Three (3) missed doses)
-Ceftriaxone Sodium Solution 1 GM on 5/1/21 (One (1) missed dose)

The total number of doses of significant medications that Resident #17 missed from March 1, 2021, to May 1, 2021, totaled 27.

Record review revealed that Resident #17 did not receive his insulin and antibiotic therapy as ordered and likely contributed to worsening of the resident's wounds.

Resident #7

Record review of the Admission Record revealed Resident #7 was initially admitted on 9/4/2018 and readmitted on 4/13/2021.

Record review of Resident #7's Diagnosis Information included Type 2 Diabetes Mellitus, Heart Failure, Cardiomegaly, Cerebral Infarction, and Essential Hypertension.

Record review of the Discharge Minimum Data Set (MDS) dated April 18, 2021, revealed that the Resident #7 has a Brief Interview for Mental Status (BIMS) score of 05, which indicates that Resident #7 is severely cognitively impaired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 191	{F 755}		

Record Review of Resident #7's Physician Orders revealed the following Physician Orders:
1. Xarelto Tablet 20 MG Give 1 tablet by mouth one time a day for Atrial Fibrillation with supper (Ordered 8/24/20)
2. Augmentin Tablet 875-125 MG Give 1 tablet by mouth two times a day for infection for 7 days. (Ordered 4/13/21)

Review of Resident #7's MAR reveals that the resident did not receive the following dose(s) of ordered medication because it was unavailable:
-Xarelto on 3/9/21, 3/30/21, 3/31/21, 4/1/21, 4/13/21, 4/14/21, 4/15/21, and 4/17/21 (Eight (8) missed doses)
-Augmentin on 4/13/21 (One (1) missed dose)
The total number of doses of significant medications that Resident #7 missed from March 1 to April 30, 2021, totaled 9.
Review of Resident #7's Admission Record revealed that the resident has Atrial Fibrillation (a heart condition that can cause stroke or death).
Resident #10
Record review of the Admission Record revealed Resident #10 was admitted to the facility on 3/15/2021.
Record review of Resident #10's Diagnosis Information included Alcohol Dependence, Seizures, Stroke, Alcohol Abuse with Withdrawal, and Dementia.
Record review of the Admission Minimum Data Set (MDS) dated March 22, 2021, reveals Resident #10 has a Brief Interview for Mental Status (BIMS) score of 03, which indicates that Resident #10 is severely cognitively impaired.

Review of Resident #10's Physician orders revealed the following Physician orders:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 192 1. Clopidogrel Bisulfate 75 mg by mouth one time a day related to stroke (Ordered 3/16/21) 2. Levetiracetam Solution 100 mg/milliliter (ML) by mouth two times a day related to seizures (Ordered 3/15/21) 3. Cyanocobalamin Tablet 1000 MCG give 1 tablet by mouth one time a day related to Alcohol Dependence (Ordered 3/16/21) 4. Folic Acid Tablet 1 MG Give 1 Tablet by mouth one time a day related to Alcohol Dependence (Ordered 3/16/21) 5. Gabapentin Capsule 100 MG Give 1 capsule by mouth three times a day for Neuropathy (Ordered 3/15/21) 6. Thiamine HCL Tablet 100 MG Give 1 tablet by mouth one time a day related to Alcohol Dependence (Ordered 3/16/21) Review of Resident #10's MAR reveals that the resident did not receive the following dose (s) of medications because they were unavailable: -Clopidogrel Bisulfate on 3/16/21, 3/17/21, 3/31/21, 4/3/21, 4/4/21, 4/5/21, 4/6/21, 4/8/21, 4/9/21, 4/12/21, 4/13/21, 4/14/21, and 4/15/21 (13 missed doses) -Levetiracetam Solution one dose of the ordered medication on 3/16/21, 3/17/21, 4/2/21 and 4/19/21 (Four (4) missed doses) -Cyanocobalamin on 3/16/21, 3/17/21, 3/18/21, 3/22/21, 3/23/21, and 3/24/21 (Nine (9) missed doses) -Folic Acid on 3/16/17, 3/18/21, 4/3/21, 4/4/21, 4/5/21, 4/6/21, 4/8/21, 4/9/21, 4/12/21, 4/13/21, 4/14/21, and 4/15/21 (Ten (10) missed doses) -Gabapentin on 3/16/21, 3/17/21, 3/23/21, 4/1/21, 4/2/21, 4/3/21, 4/4/21, 4/5/21, 4/6/21, 4/7/21, 4/8/21, 4/8/21, 4/10/21, 4/11/21, 4/12/21, 4/13/21, 4/14/21 and 4/15/21 (41 missed doses) -Thiamine on 3/16/21, 3/17/21 and 4/2/21 (2	{F 755}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 193	{F 755}		

missed doses)

The total number of doses of significant medications that Resident #10 missed from March 1 to April 30, 2021, totaled 79.

Resident #11

Record review of the Admission Record revealed Resident #11 was admitted to the facility on 12/15/2018.

Record review of Resident #11's Diagnosis Information included Type 2 Diabetes Mellitus, Seizures, Chronic Pancreatitis, Essential Hypertension, Vitamin B12 Deficiency Anemia, Recurrent Depressive Disorders, Bipolar Type Schizoaffective Disorder, and Chronic Obstructive Pulmonary Disorder.

Record review of the Quarterly Minimum Data Set (MDS) dated May 5, 2021, reveals that the Resident #11 has a Brief Interview for Mental Status (BIMS) score of 15, which indicates that Resident #11 is cognitively intact.

Record Review of the Physician orders revealed that Resident #11 had the following Physician Orders:
1. Amantadine HCL 100 mg by mouth two (2) times a day for Extrapyramidal Side Effects (Ordered 12/15/18)
2. Creon Delayed Release two (2) capsules by mouth before meals for Chronic Pancreatitis (Ordered 9/15/20)
3. Divalproex Sodium Delayed Release 500 mg by mouth two (2) times a day for convulsive disorder (Ordered 12/15/18)
4. Escitalopram Oxalate 20 mg by mouth a day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 194 for Depression (8/17/19) 5. Losartan Potassium 25 mg by mouth in the morning related to Essential (Primary) Hypertension (Ordered 7/6/20) 6. Metformin HCL 1000 mg by mouth two (2) days a day for Diabetes (Ordered 12/17/18) 7. Risperdal 2 mg by mouth two (2) times a day related to Bipolar Disorder (8/8/19) Review of Resident #11's MAR reveals that the resident did not receive the ordered medications on the following dates, as medication was unavailable: -Amantadine HCL on 3/1/2021, 3/2/2021, 3/4/2021, 3/8/2021, 3/9/2021, 3/10/2021, and 3/11/2021 (Seven (7) doses) -Creon on 3/29/2021 and 3/30/31 (Five (5) doses) -Divalproex Sodium on 3/1/2021, 3/2/21021, 3/4/2021, 3/8/2021, 3/9/2021, 3/10/2021, 3/11/2021 4/14/2021 (Nine (9) doses) -Escitalopram Oxalate on 3/1/2021, 3/2/2021, 3/4/2021, 3/8/2021, 3/9/2021, 3/10/2021, and 3/11/2021 (Seven (7) doses) -Losartan Potassium on 3/1/2021, 3/2/2021, 3/4/2021, 3/8/2021, 3/9/2021, 3/10/2021, and 3/11/2021 (Seven (7) doses) -Metformin on 3/1/2021, 3/2/2021, 3/3/2021, 3/4/2021, 3/8/2021, 3/9/2021, 3/10/2021 and 3/11/2021 (Nine (9) doses) -Risperdal on 3/1/2021, 3/2/2021, 3/3/2021, 3/5/2021, 3/8/2021, 3/9/2021, 3/10/2021 and 3/11/2021 (13 doses) The total number of missed doses of significant medications that Resident #11 missed from March 1 to April 30, 2021, totaled 57. On 5/6/2021 at 9:40 AM, in an interview with Resident #11, she revealed the resident that her	{F 755}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 195	{F 755}		

medications are not always available. She was able to recall not getting Metformin for three (3) consecutive days. She said that if there was a time that she did not take her medications, she did not refuse them, it was because the Facility ran out of her medications. She further stated that this happens almost monthly.

Resident #8

Record review the Admission Record revealed Resident #8 was initially admitted to the facility on 8/8/2019 and readmitted on 11/28/2020.

Record review of the Quarterly Minimum Data Set (MDS) dated April 13, 2021, revealed that Resident #8 has a Brief Interview for Mental Status (BIMS) score of 13, which indicates that Resident #8 is cognitively intact.

Record review of Resident #8's Diagnosis Information included, Type 2 Diabetes Mellitus, Congestive Heart Failure, Cerebral Vascular Accident, Encephalopathy, Local Infection of the Skin and Subcutaneous Tissue, and Recurrent Major Depression Disorder.

Physician orders reveals that Resident #8 had the following Physician Orders:
1. Chewable Aspirin Tablet 81 mg by mouth one time a day related to Congestive Heart Failure (Ordered 8/7/19)
2. Carvedilol Tablet 6.25 mg by mouth two (2) times a day related to Essential Hypertension (Ordered 8/7/19)
3. Clopidogrel Bisulfate 75 mg by mouth one (1) time a day for blood clot prevention (Ordered 8/7/19)
4. Escitalopram Oxalate 20 mg by mouth one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 196 time a day for Depression (Ordered 8/7/19) 5. Jardiance 25 mg by mouth one (1) time a day related to Type 2 Diabetes Mellitus (Ordered 4/7/20) 6. Lantus Solution 100 unit/mL 30 units subcutaneously one (1) time a day related to Type 2 Diabetes Mellitus (Ordered 8/20/20) 7. Losartan Potassium Tablet 25 MG Give 1 tablet by mouth one time day related to Essential Hypertension (Ordered 1/27/20) 8. Metformin HCL Extended Release give 500 mg by mouth one (1) time a day related to Type 2 Diabetes Mellitus (Ordered 4/7/20) 9. Bactrim DS 800-180 mg by mouth two times a day for infection to left great toe for ten (10) days (Ordered 2/23/21) Review of Resident #8's MAR reveals that the resident did not receive the ordered medications on the following dates, as the medication was unavailable: -Aspirin on 3/1/2021, 3/2/2021, 3/4/2021, 3/5/2021, 3/10/2021, and 3/11/2021 (Six (6) missed doses) -Carvedilol on 3/1/2021, 3/4/2021, 3/5/2021, and 3/10/2021 (Four (4) missed doses) -Clopidogrel Sulfate on 3/1/2021, 3/2/2021, 3/4/2021, 3/5/2021, 3/5/2021, 3/9/2021, and 3/10/2021 (Seven (7) missed doses) -Escitalopram Oxalate on 3/1/2021, 3/2/2021, 3/4/2021, 3/5/2021, 3/10/2021, and 3/11/2021 (Six (6) missed doses) -Jardiance on 3/1/2021, 3/2/2021, 3/4/2021, 3/5/2021, 3/10/2021, and 3/11/2021 (Six (6) missed doses) -Lantus on 3/1/2021, 3/2/2021, 3/4/2021, 3/5/2021, 3/10/2021, and 3/11/2021 (Six (6) missed doses) -Losartan Potassium on 3/1/2021, 3/2/2021,	{F 755}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 197 3/4/2021, 3/5/2021, 3/7/2021, 3/10/2021, and 3/11/2021 (Seven (7) missed doses) -Metformin on 3/1/2021, 3/4/2021, 3/5/2021, and 3/9/2021 (Four (4) missed doses) -Bactrim DS on 3/1/21, 3/4/21 and 3/5/21 (Three (3) missed doses) The total number of doses of significant medications that Resident #8 missed from March 1 to April 30, 2021, totaled 49. Resident #16 Record review the Admission Record reveals Resident #16 was admitted to the facility on 2/26/21 and readmitted to the facility on 4/16/21. Record review of Resident #16's Diagnosis Information include Schizophrenia, Seizures, Essential Hypertension, and Cellulitis of Left Lower Limb. Record review of the admission Minimum Data Set with an assessment reference date of 4/21/21 revealed Resident #16 had a Brief Interview of Mental Status score of 14 indicating that the resident was cognitively intact. Record Review of the Physician orders reveals that Resident #16 had the following Physician Orders: 1. Amlodipine Besylate 10 MG give 1 tablet by mouth one time a day related to Essential Hypertension (Ordered 2/26/21) 2. Furosemide 20 MG give 1 tablet by mouth one time a day related to Edema (Ordered 2/26/21) 3. Lisinopril 10 MG give 1 tablet by mouth one time day related to Essential Hypertension	{F 755}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 198 (Ordered 2/26/21) 4. Levetiracetam 250 MG give 1 tablet by mouth one time a day related Seizures (Ordered 2/26/21) 5. Metoprolol Tartrate 50 MG give 1 tablet by mouth two times a day related to Essential Hypertension (Ordered 2/26/21) 6. Haldol Solution 5 MG/ML Inject 5 m intramuscularly every 6 hours related to Restlessness and agitation (Ordered 2/26/21) 7. Quetiapine Fumarate 100 MG give 2 tablets by mouth two times a day related to Schizophrenia (Ordered 4/16/21) 8. Fluoxetine HCL 10 MG give 1 tablet by mouth one time a day related to Schizophrenia (Ordered 4/16/21) 9. Divalproex Sodium Tablet Delayed Release 500 MG Give 1 tablet by mouth one time a day related to Seizures (Ordered 4/17/21) 10. Bactrim DS 800-160 MG give 1 tablet by mouth two times a day for cellulitis (Ordered 4/27/21) 11. Haldol Tablet 10 MG Give 1 tablet by mouth two times a day for Agitation Review of Resident #16's MAR reveals that the resident did not receive the ordered medications on the following dates, as the medication was unavailable: -Amlodipine Besylate on 3/1/21 and 4/16/21 (Two (2) missed doses) -Furosemide on 3/1/21, 3/2/21 and 4/16/21 (three (3) missed doses) -Lisinopril on 3/1/21, 3/2/21, and 4/16/21 (Three (3) missed doses) -Levetiracetam on 3/2/21, 4/16/21, 4/26/21 and 4/27/21 (Four (4) missed doses) -Metoprolol on 3/1/21, 3/2/21, 4/16/21, 4/26/21 and 4/27/21 (Seven (7) missed doses)	{F 755}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 199 -Quetiapine Fumarate on 3/1/21, 3/2/21, 4/16/21, 4/17/21 and 4/18/21 (Four (4) missed doses) -Fluoxetine on 4/17/21 (One (1) missed dose) -Divalproex Sodium on 4/17/21 and 4/19/21 (Two (2) missed doses) -Bactrim DS on 4/27/21, 4/28/2/1 and 4/30/21 (Three (3) missed doses) -Haldol Solution on 5/2/21, 5/3/21, 5/4/21, 5/5/21 and 5/6/21 (15 missed doses) -Haldol Tablet on 5/6/21 (One (1) missed dose) The total number of doses of significant medications that Resident #16 missed from March 1 to May 9, 2021, totaled 45. Resident # 1 Record review of Resident #1's Admission Record revealed Resident #1 was admitted to the facility on 3/17/2021. Record review of Resident #1 Diagnosis Information included Unspecified Dementia with Behavioral Disturbance, Epilepsy, Cognitive Communication Deficit, Generalized Anxiety Disorder, Mood Disorder with Known Physiological Condition with Manic Features, Hypothyroidism, and Angina Pectoris. Record review of the Admission Minimum Data Set (MDS) dated 3/23/2021, revealed a Brief Interview of Mental Status (BIMS) score of 00, indicating that Resident #1 has severe impairment in cognition. Record Review revealed that Resident #1 had the following Physician Orders: 1. Quetiapine Fumarate Tablet 25 MG Give 1 tablet by mouth at bedtime for Dementia	{F 755}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 200 (Ordered 3/25/21) 2. Aricept Tablet 10 MG Give 1 tablet by mouth at bedtime for Dementia (Ordered 4/30/21) 3. Seroquel Tablet 300 MG Give 300 mg by mouth at bedtime for Dementia with Behavioral problems related to Mood Disorder due to known physiological condition with manic features. (Ordered 4/30/21) 4. Alprazolam Tablet 1 MG Give 1 tablet by mouth two times a day for Agitation and Anxiety (Ordered 4/5/21) 5. Divalproex Solution Tablet Delayed Release 250 MG Give 1 tablet by mouth two times a day related to Epilepsy (Ordered 4/30/21) 6. Namenda Tablet 5 MG Give 1 tablet by mouth two times a day related to unspecified Dementia with Behavioral Disturbance (Ordered 4/30/21) 8. Olanzapine Tablet 10 MG Give 1 tablet by mouth three times a day related to Mood Disorder due to known physiological condition with Manic Features (Ordered 4/30/21) 9. Alprazolam Tablet 0.5 MG Give 1 tablet by mouth one time a day related to Generalized Anxiety Disorder (Ordered 5/1/21) 10. Prednisone Tablet 10 MG Give 1 tablet by mouth one time a day for right foot pain for 5 days (Ordered 5/2/2021) Review of Resident #1's MAR reveals that the resident did not receive the ordered medications on the following dates, as the medication was unavailable: -Quetiapine Fumarate on 3/27/21 and 4/30/21 (Two (2) doses missed) -Aricept on 4/30/221 ((One (1) dosed missed) -Seroquel on 4/30/21 (One (1) dose missed) -Alprazolam on 5/5/21 and 5/6/21 (Two (2) missed doses) -Divalproex on 4/30/21, 5/5/21 and 5/6/21 (Three	{F 755}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 201	{F 755}		

(3) missed doses)
-Namenda on 4/30/21 (One (1) dose missed)
-Olanzapine on 5/5/21 and 5/6/21 (Four (4) doses missed)
-Alprazolam on 5/5/21 and 5/6/21 (Two (2) doses missed)
-Prednisone on 5/2/21, 5/5/21 and 5/6/21 (Three (3) doses missed)

The total number of doses of significant medications that Resident #1 missed from March 17 to May 7, 2021, totaled 19.

Resident #2

Record review of the Admission Record revealed Resident #2 was admitted to the facility on 6/19/2020.

Record review of Resident #2's Diagnosis Information included Type 2 Diabetes Mellitus, Chronic Embolism with Thrombosis, Unspecified Fracture of Shaft of Left Fibula, Atherosclerotic Heart Disease, Pressure Ulcer of Sacral Region, and Chronic Kidney Disease.

Record review of Resident #2's Quarterly Minimum Data Set (MDS) dated 3/9/2021, reveals a Brief Interview for Mental Status (BIMS) score of 07. A BIMS score of 07 indicates Resident #2 is severely cognitively impaired.

Record Review of the Physician orders reveals that Resident #2 had the following Physician Orders:
1. Eliquis 5 MG Give 5 mg by mouth two (2) times a day for anticoagulant (Ordered 6/18/20)
Review of Resident #2's MAR reveals that the resident did not receive the ordered dose (s) of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 202	{F 755}		

Eliquis 3/1/21 (One (1) dose missed), 3/2/21 (One (1) dose missed), 3/4/21 (One (1) missed dose), 3/5/21 (One (1) missed dose), 3/8/21 (Two (2) missed doses), 3/9/21 Two (2) missed doses), 3/10/21 (One (1) missed dose), 3/18/21 (One (1) missed dose), 3/19/21 (One (1) missed dose) , 3/22/21 (One (1) missed dose), 3/23/21 (One (1) missed dose), 4/8/21 (Two (2) missed doses), 4/9/21 (Two (2) missed doses), 4/10/21 (One (1) missed dose), 4/12/21 (Two (2) missed doses) and 4/13/21 (Two (2) missed doses), as the medication was unavailable.

The total number of doses of significant medications that Resident #2 missed from March 1 to April 30, 2021, totaled 22.

Resident #9

Record review of the Admission Record revealed Resident #9 was originally admitted on 10/16/2020 and re-admitted on 2/11/2021.

Record review of Resident #9's Diagnosis Information included Type 2 Diabetes Mellitus, Essential Hypertension, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Peripheral Vascular Disease, and Cerebral Infarction.

Record review of the Quarterly Minimum Data Set (MDS) dated April 8, 2021, revealed that the resident has a Brief Interview for Mental Status (BIMS) score of 15, which indicates that the resident is cognitively intact.

Review of Resident #9's Physician Orders reveal orders for:
1. Aspirin EC Tablet Delayed Release 81 MG

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 203 Give 1 tablet by mouth one time a day for Cerebrovascular Accident (CVA) (Ordered 10/20/20) 2. Amlodipine Besylate Tablet to MG Give 1 tablet by mouth one time a day for Essential Hypertension (Ordered 11/3/20) 3. Potassium Chloride ER Tablet Extended Release 20 MEQ Give on tablet by mouth one time a day for diuretic use (Ordered 1/12/21) 4. Losartan Potassium Tablet 50 MG Give 50 mg by mouth in the morning for Hypertension (Ordered 1/15/21) 5. Furosemide Tablet 40 MG Give 1 tablet by mouth in the morning for Hypertension/Edema related to Essential Hypertension (Ordered 1/26/21) 6. Humulin 70/30 Suspension 100Unit/ML Inject 50 units subcutaneously two times a day related to Type 2 Diabetes Mellitus (Ordered 2/11/21) Review of Resident #9's's MAR reveals that the resident did not receive the ordered medications on the following dates, as the medication was unavailable: -Aspirin EC Tablet on 3/1/21 and 3/9/21 (Two (2) doses missed) -Amlodipine Besylate on 3/1/21 and 3/9/21 (Two (2) doses missed) -Potassium Chloride ER on 3/4/21, 3/8/21 and 3/9/21 (Three (3) doses missed) -Losartan Potassium on 3/1/21 and 3/8/21 (Two (2) doses missed) -Furosemide on 3/1/21, 3/4/21, 3/8/21 and 3/10/21 (Four (4) doses missed) -Humulin 70/20 on 3/1/21, 3/8/21 and 3/10/21 (Three (3) doses missed) The total number of doses significant medications that Resident #9 missed from March 1 to April 30, 2021, totaled 16.	{F 755}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 204	{F 755}		

Resident #15

Record review of the Admission Record revealed Resident #15 was admitted to the facility on 11/25/2020.

Record review of Resident #15's Diagnosis Information included Chronic Pain Syndrome, Type 2 Diabetes Mellitus, Essential Hypertension, and Hypertensive Heart Disease.

Record review of Resident #15's Quarterly Minimum Data Set (MDS) dated 2/25/2021, revealed a Brief Interview for Mental Status (BIMS) score of 12 indicating Resident #15 is moderately cognitively impaired.

Review of Resident #15's Physician Orders revealed that the Physician Orders include orders for Lyrica 100 mg by mouth three (3) times a day related to Muscle Spasm of Back.

Review of the Resident #15's MAR reveals that the resident did not receive the ordered medicine on 3/9/19 (Two (2) doses missed), 3/18/21 (Two (2) doses missed) and 4/6/21 (Three (3) doses missed) because it was unavailable.

The total number of doses of significant medications that Resident #10 missed from March 1 to April 30, 2021, totaled 7.

On 5/13/21 at 11:55 AM in an interview with Resident #15, he revealed that he needs his Lyrica and pain medications and would never refuse them. He stated that the only time he does not take his medications is when the facility has run out of them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 205	{F 755}		

Removal Plan:
The ADON/ICC was in-serviced regarding the process for obtaining medications from the pharmacy, including the back-up pharmacy process, on 5/22/2021 by the Regional Nurse Consultant. The ADON initiated education regarding obtaining medications from the pharmacy, the back-up pharmacy process, and completing match backs daily for all nurses on 5/22/2021.
The attending physician was notified of the missed medications on 5/25/2021 by Medical Records with no new orders at that time.
On 6/01/21, the Owner sent a letter of termination of services for the current Pharmacy Service and a new company will take over in 30 days. There will be no lapse in pharmacy services for the residents.
Validation:
The State Survey Agency (SSA) validated through interview with the Assistant Director of Nursing/Infection Control Coordinator (ADON/ICC) that she had been in-serviced by the Regional Nurse Consultant on obtaining medications from the pharmacy that included information about the back-up pharmacy process.
The SSA validated through review of sign-in sheets and interviews with licensed nurses the ADON/ICC conducted in-services for all licensed nurses regarding obtaining medications from the pharmacy, the back-up pharmacy process, and completing match backs daily.
The SAA validated through interview with the attending physician that he had been notified of missed medications.
The SSA validated through interviews with licensed nurses from all shifts that in-services conducted on obtaining medications were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 206 mandatory and attendance was required before being permitted to work. The SSA validated through interviews that the facility is now using Liberty Pharmacy, with Walgreens as their back-up. All nurses interviewed, including the ADON verified that they were receiving the medications as ordered and if they ran out, they called Liberty Drugs and the medications would be delivered the same day. The nurses stated that they were no longer having a problem with having the medications that were ordered for their residents.	{F 755}		
{F 759} SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to maintain a medication error rate less than 5% as evidenced by failure to have two (2) medications available for one (1) of three (3) residents observed for medication administration. Resident #8. The medication error rate was 8%. Findings include: Record review of the Facility's "Administration of Drugs" policy dated 06/01/2000 revealed the purpose of the policy is residents receive their medications in a timely basis and in accordance with our established policies.	{F 759}	1. The Assistant Director of Nursing/Infection Control Coordinator was in-serviced regarding the process for obtaining medications from the pharmacy, including the back-up pharmacy process, on 5/22/2021 by the Regional Nurse Consultant. The ADON initiated education regarding obtaining medications from the pharmacy, the back-up pharmacy process, and completing match backs daily for all nurses on 5/22/2021. On 5/5/21 the Licensed Practical Nurse ordering the medications that were not available for administering to Resident #8 from the pharmacy to be delivered that night. the medications arrived that night to	7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 759}	Continued From page 207 On 05/05/2021 9:10 AM, in an observation of medication pass with LPN #6 administering medication to Resident #8, two (2) medications were not available on the medication (med) cart for administering. When asked LPN #6, who orders medications, she explained the med cart nurses are responsible for reordering medications as needed but there have been several nurses who do not order medications. Observed LPN #6 administering medications to Resident #8 and no information was explained to the resident regarding any missing meds. When asked LPN #6 what she will do regarding the medications not available, she explained she will order meds and the meds will be delivered tonight. When asked regarding using a back-up method for obtaining meds or a back-up pharmacy, she explained there is no back up pharmacy and only have an emergency kit for medication and it has mostly antibiotics in the kit. She further explained meds are delivered on 11-7 shift if the meds are ordered before 5:00 PM and she will order the meds before she leaves at 3:00 PM. She explained the facility uses the Facility's Pharmacy. Medications missed were Topiramate 25 mg twice a day (BID) for headache prevention and Jardiance 25 mg for Diabetes. Resident #8's random blood sugar was 143 this am. State Agency (SA) asked LPN #6 what a nine (9) means on the Medication Administration Record (MAR) for medication pass, she explained nine (9) means other and a progress note is written to explain what the issue with the medication was and, in the note, it should say whether the medication is given or not. On 5/6/21 at 8:10, in an interview with LPN # 5, she explained that medications are not always	{F 759}	administer at the next scheduled dose for Resident #8. For all residents including Resident #8, the attending physician was notified of the missed medications on 5/25/2021 by Medical Records with no new orders at that time. Any medications noted as unavailable for Resident #8 were ordered and obtained from the pharmacy on 5/22/2021. On 6/01/21, the Owner sent a letter of termination of services for the current Pharmacy Service and a new company will take over in 30 days. There will be no lapse in pharmacy services for the residents. 2. All residents receiving medications have the potential to be affected by the deficit practice cited. 3. Beginning 5/24/2021 the ADON/ICC, Minimal Data Set Coordinator, and Regional Nurse Consultant conducted multiple in-services with nursing employees (Registered Nurses, Licensed Practical Nurses) regarding documentation of medication, specifically omission or not documented medications. Any staff missing in-services will not work until they receive the education. Any staff member who fails to comply with the direction of the in-services will be further educated and/or progressively disciplined. Medical Records Manager, the Assistant Director of Nursing, and the Director of Nursing completed a match back on 5/21/21 for all medication carts to ensure that all medications were available as ordered. Any medication notes as unavailable were ordered from the pharmacy and were obtained. Daily medication match backs were initiated on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 759}	Continued From page 208 available on the med cart and meds are on order. When asked what she does if meds are not available, she explained that she will call pharmacy and reorder the meds. When asked if she noticed a medication was not available for several days what would she do, she explained she would recall pharmacy and notify the Assistant Director of Nursing (ADON) and the Director of Nursing (DON). On 5/6/21 at 2:30 PM, in an interview with LPN #9, reported she has worked at the facility for 3 months. When asked regarding what to do when medications run out, she explained will first check the stock meds including over the counter meds and vitamins. She explained the facility has an emergency kit available with antibiotics. She reported the facility has a same day delivery, she explained that if the medications are ordered by 5:00 PM the medications will be delivered that night. When asked regarding a backup pharmacy, she explained the nurses used to call the local pharmacy, but now the facility only uses the Facility's Pharmacy. On 5/6/21 at 10:45 AM, in an interview with the DON, ask regarding back up pharmacy, she explained the facility uses the local pharmacy for back up pharmacy. When asked regarding if the nurses administering medications are aware of this, she explained they should be and there is a list of numbers posted at the nurse station. She explained Facility's Pharmacy must approve the use of the backup pharmacy and when ask how the Facility's Pharmacy approves, she reported the nurse must call the Facility's Pharmacy and then the pharmacy will contact the backup local pharmacy. When asked if the nurses are trained on ordering medications and reordering, she	{F 759}	5/21/21 by the medication nurses. 4. Director of Nursing or ADON will utilize the medication audit tool to monitor non-administered medication weekly times four weeks beginning 7/1/21 and monthly time three months beginning 8/1/21. New orders and non-administered meds are reviewed daily in clinical standup beginning 6/21/21. Findings will be brought to Quality Assurance Performance Improvement monthly beginning 6/7/21 for review, revision, or resolution of the plan for six months. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance continuing for three months or as needed. The Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 759}	Continued From page 209	{F 759}		

explained the nurses receive orientation from the human resource that goes over the facility policies on hire date.

On 5/6/21 at 1:30 PM, phoned Facility's Pharmacy and ask to speak to the pharmacist regarding the facility. A Pharmacy Technician answered and stated she is the individual who deals with this facility. When asked regarding medication delivery, she explained cycle meds are delivered on days 7, 14, and 21 and this depends on if the resident is skilled and then the pharmacy will only send 7 days' supply at a time such as medications as needed (PRN), including liquids and inhalers. When asked regarding medication such as Eliquis or Gabapentin, she explained anticoagulants must be re-ordered every time and Gabapentin should be delivered with cycle medications. When asked regarding back up pharmacy services, she explained the facility uses the local pharmacy but the Facility's Pharmacy must fax orders before the local pharmacy will fill medications.

On 5/11/21 at 9:00 AM, in a phone interview with the Pharmacy Consultant, he explained that he comes to the facility once a month and it is usually around the 2nd week of the month. When asked him regarding what he does when in the facility, he explained he reviews all charts, records including MARs, record reviews, chart audits, medication storage, medication administration, and narcotics. He explained once when he watched medication administration, he did notice medications not available. When asked what he advised the facility to do, he reported that he recommended to use backup pharmacy, order medications, and notify the physician. When asked did the nurses do what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 759}	Continued From page 210	{F 759}		

he recommended, he explained that he did not follow through to see if the nurses did do that. When asked had he noticed any missed doses of Eliquis or any other significant medications, he explained not really, but reported that Eliquis in not a cycle medication and the facility has had issues with it not being available. He explained the facility's ordering of medications system or process can be confusing due to using the computer to order medications. He further explained any time a medication is missed the nurse should notify the physician and the pharmacy. When asked the consultant if any harm could come from a resident missing medication, he explained it would depend on the medication and the resident and how long the resident missed the medications.

On 5/13/21 at 2:00 PM, in an interview with Pharmacy Consultant, he explained he had been in the facility today doing medication cart checks, medication administering, and chart reviews. When asked were any problems noted today, he reported that no medications were not available during medication administering. He reported the facility and Pharmacy continue to try and educate on ordering medications. He explained like I said on the telephone yesterday the ordering of medication in the computer can be confusing. He reported the facility staff turnover has been a problem consistently with facility care. He explained the pharmacy is continuing to try and expand the Emergency Kit to include a more variety of medications. He explained the Emergency Kit does include more medications other than antibiotics.

Record review of Resident #8's Admission Record revealed Resident #8 was initially

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 759}	Continued From page 211 admitted on 8/8/2019 and readmitted on 11/28/2020 with the diagnoses of Type 2 Diabetes Mellitus, Congestive Heart Failure, Cerebral Vascular Accident, Encephalopathy, Local Infection of the Skin and Subcutaneous Tissue, and Recurrent Major Depression Disorder. The Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of April 13, 2021, Section C revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 13, which means that Resident #8 is cognitively intact. A record review of Resident #8's Physician Orders revealed orders for Jardiance 25 milligram (mg) give one tablet by mouth one time a day related to Type 2 Diabetes, and Topiramate 25 mg give one tablet by mouth two times a day for headache prevention.	{F 759}		
{F 760} SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, facility policy review and record review the facility failed to ensure significant medications (e.g., anticoagulants, anti-seizure, heart, antidiabetic, steroids, COVID-19 regimen medications, psychotropic and antibiotics) were administered to prevent discomfort or complications for 12 of 17 sampled residents reviewed for medication administration. (Resident #1, #2, #4, #7, #8, #9, #10, #11, #12, #15, #16,	{F 760}	1. The Assistant Director of Nursing/Infection Control Coordinator (ADON/ICC) was in-serviced regarding the process of obtaining medications from the pharmacy, including the back-up pharmacy process, on 5/22/2021 by the Regional Nurse Consultant. The ADON/ICC initiated education on obtaining medications from the pharmacy, the back-up pharmacy process, and	7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 212 and #17) This situation was determined to be an Immediate Jeopardy (IJ) which began on 11/17/2020, when Resident #4 missed 26 doses of medications ordered for COVID-19 and was hospitalized on 11/29/2020. Resident #4 subsequently expired at home. Eleven (11) other residents also missed significant medication doses. The facility Administrator was notified of the IJ on 5/21/2021 and the IJ template was given to the Administrator at 3:30 PM. The IJ and Substandard Quality of Care (SQC) existed at CFR(S): 483.45(f)(2)- Residents are free of any significant medication errors. The IJ was not removed prior to the State Agency (SA) exit on 5/26/2021 and was considered ongoing. The facility provided a Credible Removal Plan, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interviews and in-service sign-in sheets review. The facility provided evidence the facility had implemented corrective actions listed in the Credible Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for 42 CFR 483.45(f)(2) has been lowered from the scope and severity of a "K" to the scope and severity of an "E". The facility will remain out of compliance at	{F 760}	completing match backs daily for all nurses on 5/22/2021. The Medical Record□s Manager, Assistant Director of Nursing/ICC, and the Director of Nursing(DON) completed a match back for Residents #2, #7, #8, #9, #10, #11, #15, and #17 on 5/21/21 to ensure that all medications were available as ordered. Any medications noted as unavailable were ordered from the pharmacy and were obtained on 5/22/21. The attending physician was notified of the missed medications on 5/25/2021 by Medical Records with no new orders at that time Residents #2, #7, #8, #9, #10, #11, #15, and #17. Residents #1, #4, #12, and #16 are discharged; the Facility was unable to evaluate the residents that were discharged for impact. On 6/01/21, the Owner sent a letter of termination of services to the current Pharmacy Service; a new company will take over in 30 days. There will be no lapse in coverage. 2. All residents receiving medication have the potential to be affected by the deficit practice cited. 3. Beginning 5/24/2021 through 6/12/21, the ADON/ICC, Minimum Data Set Coordinator, and Regional Nurse Consultant conducted multiple in-services with nursing employees (Registered Nurses, Licensed Practical Nurses) regarding documentation of medication, specifically omission or not documented medications. Any staff missing in-services will not work until they receive the education. Any staff member who fails to comply with the direction of the in-services will be further educated and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 213 Scope and Severity of "E" that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: The Facility's failure to ensure residents received medications per physician's orders resulted in hospitalization for Resident #4 and Resident #12 expired in the facility after missing 37 significant medications. This placed other residents in a situation that is likely to cause serious harm, injury, impairment, or death. Review of the facility's policy entitled "Administration of Drugs", dated 6/1/2000, revealed: "It is the policy of this facility that residents receive their medications on a timely basis and in accordance with our established policies ....4. Medications must be charted immediately following the administration by the person administering the drugs. The date, time administered, dosage, etc., must be entered in the medical record and signed by the person entering the data." Review of the facility's policy entitled "AmPharm Backup Information", undated, revealed: ..... "2. The facility can get up to 3 days of medications to cover until our shipment reaches the facility. Getting more than a 3-day supply is not authorized. 3. If medications are needed for a patient during our hours of operation, the facility is	{F 760}	progressively disciplined. Daily medication match backs were initiated on 5/21/21 by the medication nurses to ensure that medications were obtained timely for residents to receive their medications. The Medical Record□s Manager, Assistant Director of Nursing and the Director of Nursing completed a match back on 5/21/21 of all medication carts to ensure that all medications were available as ordered. Any medications noted as unavailable were ordered from the pharmacy. 4. DON or ADON will utilize the medication audit tool to monitor non-administered medication weekly times four weeks beginning 7/1/21 and monthly time three months beginning 8/1/21. New orders and non-administered meds are reviewed daily in clinical standup beginning 6/21/21. Med Pass audits will be performed by the DON or ADON using the CMS med pass audit tool weekly times four weeks beginning 6/21/21 and monthly times three months beginning 7/21/21. Findings will be brought to Quality Assurance Performance Improvement monthly beginning 7/2/21 for review, revision, or resolution of the plan. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance and will continue for 3 months or as needed. The Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 214	{F 760}		

to contact AmPharm, and we will take care of the backup process. 4. If medications are needed for a patient during hours that AmPharm is closed, the facility is to contact the after-hours pharmacy and they will take care of getting the medications filled and delivered to the facility. The facilities are not authorized to contact backup directly for medication fills. They are to contact the AmPharm or the after-hours pharmacy. This is to keep costs down and to have a record of medications we need to send without duplicating items."

On 5/5/21 at 9:10 AM, in an observation and interview of medication pass with Licensed Practical Nurse (LPN) #6, two (2) medications were unavailable for administration. Resident #8 did not receive Topiramate 25 milligrams (MG) ordered for headache prevention and Jardiance 25 MG ordered for Diabetes. LPN #6 stated that there is no back up pharmacy and that the facility has an emergency kit for medications, but it contains mostly antibiotics. She further stated when medications are not given, the nurse records the number "9" in the signature box and that prompts the nurse to enter a note in the Progress Notes to explain the issue with the medication.

On 5/6/2021 at 8:10 AM, an interview with LPN #5, revealed that medications are not always available on the medication cart and medications are on order.

On 5/6/2021 at 10:45 AM, in an interview with the Director of Nurses (DON), regarding back up pharmacy, she explained that the facility uses the Local Pharmacy (LP) for back up. She stated that if medications are needed, the nurses must contact the Facility's Pharmacy (FP) and they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 215	{F 760}		

contact the back-up pharmacy. She explained that the nurses are not trained on ordering medications but when they are hired, they receive orientation on facility policies from Human Resource.

On 5/6/2021 at 2:30 PM, an interview with LPN #9 revealed that she has worked at the facility for three (3) months. She explained that the nurses used to use LP Pharmacy for back-up meds, but now the facility only uses the FP.

On 5/6/2021 at 3:55 PM, in an interview with the Medical Nurse Practitioner (MNP), she revealed that the residents have told her they have not been receiving their medications. She stated that when residents have complained, she would ask the nurses about the medications, and they would tell her that the medications were on order.

On 5/8/2021 at 12:20 PM, in an interview with LPN #7, she revealed that she has worked at the facility for two (2) months. LPN #7 stated that the facility has not used back up pharmacy since March 2021. She further explained that Eliquis is not a cycle medication and there is a problem with getting that medication in a timely manner.

On 5/8/2021 at 1:20 PM, in an interview with LPN #8, she revealed that she has worked at the facility for five (5) years and that there has not been any training on ordering or reordering medications.

On 5/20/2021 at 9:15 AM, in an interview with the (DON) she stated that most of the nurses are new graduates and have not been educated on medications. The DON stated that she was aware that the nurses were unable to get medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 216	{F 760}		

and that she had told the nurses to document everything because she had told the Administrator that the medications were not coming in and she did not know what else to do.

On 5/20/2021 at 10:15 AM, in an interview with the Nurse Consultant, she stated she had spoken to the DON and that she had recommended that the DON in-service the staff on the appropriate way to get medications. However, she stated that the DON did not follow up and present the in-services to the nurses. The Nurse Consultant further stated that she has had trouble getting responses from the DON.

On 5/20/21 at 12:30 PM, in an interview with the Medical Doctor #2 (MD #2), she stated that she is aware that residents do not get their medications in a timely manner and there are times that residents go for days without medication. She stated that most of the time she is not notified for several days of residents not receiving their medications. The MD said that when she has questioned the nurses regarding medications not being given, she is told that the medications are on order. The MD said that she has met with the Administrator and DON about her concerns.

On 5/20/2021 at 1:00 PM, in a telephone interview with the Medical Director, he stated that he was aware of medication not being available, but he had thought the facility had corrected the problem. The Medical Director stated that he should have followed up on the deficient practice and should have known about the deficient issues within the Facility through Quality Assurance and Performance Improvement (QAPI).

On 5/20/2021 at 2:00 PM, in an interview with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 217	{F 760}		

Administrator, he confirmed that he is aware that the Facility has a system failure with medication administration. He stated that during the QAPI meeting in April it was discussed that there are medications that are not being given. He further stated that the Director of Nursing is supposed to call the pharmacy when a medication is not available.

On 5/20/2021 at 2:30 PM, in a telephone interview with the Owner of the Facility, he said that he was aware of the medication issues, "but I did not know how severe it was." He stated that the QAPI program failed.

Resident #4

Record review of the Admission Record revealed Resident #4 was admitted to the facility on 8/15/2017 and readmitted on 10/27/2020.

Record review of Resident #4's Diagnosis Information included COVID-19, Heart Failure, Type 2 Diabetes Mellitus, Recurrent Major Depressive Disorder, Acute Kidney Failure, Chronic Obstructive Pulmonary Disease, and Anxiety Disorder.

Record review of the Admission Minimum Data Set (MDS) dated 11/1/2020 revealed that Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicates that Resident #4 was cognitively intact.

On 11/17/2020, Resident #4 tested positive for COVID-19 and the Physician ordered the following medications:
1. Azithromycin Tablet 250 Give 500 milligrams (MG) by mouth one time a day for infection for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 218	{F 760}		

one (1) day
2. Dexamethasone Tablet 6 MG Give 1 tablet by mouth one time a day for COVID-19 for 10 days
3. Zinc Sulfate Capsule 20 Mg Give 1 capsule by mouth two times a day for COVID-19
4. Famotidine Tablet 40 MG Give 2 tablets by mouth three times a day for COVID-19 for 30 days

Review of Resident #4's Medication Administration Record (MAR) revealed that the resident did not receive the following dose(s) of medications because they were unavailable:
-Azithromycin 500 mg - 11/18/20 (1 of 1 dose missed)
-Dexamethasone - 11/18/2020, 11/20/2020 and 11/25/2020 (Three (3) missed doses) -Famotidine - 11/17/2020, 11/18/2020, 11/22/2020, 11/23/2020, 11/24/2020, 11/25/2020, and 11/27/2020 (Nine (9) missed doses)
-Zinc - 11/17/2020, 11/18/2020, 11/19/2020, 11/20/2020, 11/22/2020, 11/23/2020, 11/24/2020, 11/25/2020 (13 missed doses)

Resident #4 missed a total of 26 doses of significant medication ordered for COVID-19 from November 17 to November 27, 2021.

Resident #4 was transferred to the hospital Emergency Room for evaluation on 11/29/2020 and subsequently died.

A telephone interview on 05/04/2021 at 01:00 PM, with Resident #4's mother revealed Resident #4 contracted COVID-19 at the facility and was transferred to the hospital. The resident's mother stated when the facility called to inform her of Resident #4's transfer to the hospital, she went to the hospital and doctors told her there was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 219	{F 760}		

nothing more that could be done for her daughter. She stated that the doctor at the hospital said that he did not know what had happened, but maybe she had missed medications. The resident's mother decided to take her home rather than her being discharged back to the facility and her daughter expired at home on 12/22/2020.

Resident #12

Record review of the Admission Record revealed Resident #12 was initially admitted to the facility on 10/24/2020 and readmitted on 1/6/2021.

Record review of Resident #12's Diagnosis Information included Unspecified Atrial Fibrillation, Peripheral Vascular Disease, Chronic Embolism and Thrombosis of Unspecified Deep Veins of Unspecified Lower Extremity, Chronic Kidney Disease, and Essential Hypertension.

Record review of the Quarterly Minimum Data Set (MDS) dated April 16, 2021, revealed that Resident #12 has a Brief Interview for Mental Status (BIMS) score of 14, which indicates that Resident #12 is cognitively intact.
Record review of Resident #12's Physician Orders revealed that the physician ordered the following medications:
1. Gabapentin Capsule 100 Grams (GM) Give 1 capsule by mouth three times a day for neuropathy (Ordered on 10/23/20)
2. Apixaban 5 mg by mouth two times a day for Deep Vein Thrombosis (Ordered 1/14/21)

Review of Resident #12's MAR reveals that the resident did not receive the following dose(s) of medications because they were unavailable:
-Gabapentin on 4/5/21, 4/6/21, 4/7/21, 4/8/21,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 220 4/9/21, 4/10/21, 4/11/21, 4/12/21, 5/2/21, 5/3/21, and 5/7/21 (24 missed doses) -Apixaban on 4/13/21, 4/14/21, 4/15/21, 4/16/21, 4/17/21, 4/18/21, 4/19/21, 4/25/21, 4/26/21, 4/27/21, 5/9/21 and 5/13/21 (13 missed doses) The total number of doses of significant medications that Resident #12 missed from April 1 to May 16, 2021, totaled 37. Resident #12 was found unresponsive on May 17, 2021. Resident #12 expired at the facility. Resident #17 Record review the Admission Record revealed Resident #17 was originally admitted to the facility on 3/4/2021 and readmitted on 3/10/2021. Record review of Resident #17's Diagnosis Information revealed, Osteomyelitis of Vertebra, Sacral and Sacrococcygeal Region, Unstageable Pressure Ulcer of Sacral Region, Gram Negative Sepsis, Congestive Heart Failure, Atherosclerotic Heart Disease, Diabetes Mellitus due to Underlying Condition with Foot Ulcer, Chronic Obstructive Pulmonary Disease, Chronic Peripheral Venous Insufficiency and Essential Hypertension. Record review of the 5-Day Minimum Data Set (MDS) dated March 12, 2021 revealed that the resident has a Brief Interview for Mental Status (BIMS) score of 15, which indicates that Resident #17 is cognitively intact. Record Review of Resident #17's Physician Orders revealed the following Physician Orders: 1. Insulin Glargine Solution Inject 60 units	{F 760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 221	{F 760}		

subcutaneously at bedtime related to Diabetes Mellitus due to underlying condition with foot ulcer (Ordered 3/4/21)
2. Insulin Aspart Solution Inject 5 units subcutaneously three times a day related to Diabetes Mellitus due to underlying condition with foot ulcer (Ordered 3/4/21)
3. Metoprolol Tartrate Tablet 25 MG Give 1 tablet by mouth two times a day related to Essential Hypertension (3/4/21)
4. Furosemide Tablet 40 MG Give 1 tablet by mouth one time a day related to Congestive Heart Failure (Ordered 3/5/21)
5. Isosorbide Mononitrate ER Tablet 60 MG Give 1 tablet by mouth one time a day related to Atherosclerotic Heart Disease (Ordered 3/4/21)
6. Insulin Glargine Solution Inject 60 units subcutaneously in the evening related to Diabetes Mellitus due to underlying condition with foot ulcer (Ordered 3/10/21)
7. Insulin Glargine Solution 100 Init/ML Inject 15 units subcutaneously in the morning for Diabetes Mellitus due to underlying condition with foot ulcer (Ordered 3/4/21)
8. Insulin Aspart Solution Inject 5 units subcutaneously three times a day related to Diabetes Mellitus due to underlying condition with foot ulcer (Ordered 3/10/21)
9. Furosemide Tablet 20 MG Give 1 tablet by mouth one time a day related to Congestive Heart Failure (Ordered 3/10/21)
10. Clindamycin HCL Capsule 300 MG Give 1 capsule by mouth every dayshift for infection related -Gram-Negative Sepsis (Ordered 3/10/21)
11. Levofloxacin Tablet 750 MG Give 1 tablet by mouth one time a day related to Gram Negative Sepsis for 14 days (Ordered 3/10/21)
12. Cipro Tablet 500 MG Give 1 tablet by mouth every 24 hours for Osteomyelitis for 56 days

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 222 (Ordered on 3/24/21) 13. Levofloxacin in D5W Solution 750 MG/150 ML Use 750 MG intravenously every 24 hours for osteomyelitis for 42 days infuse @100 ML/HR to PICC (Ordered 4/12/21) 14. Ceftriaxone Sodium Solution Reconstituted 1 GM intravenously one time a day for sacral wound infection for 14 days (Ordered 5/1/21) Review of Resident #17's MAR reveals that the resident did not receive the following dose(s) of ordered medications because they were unavailable: -Insulin Glargine Solution 60 units on 3/4/21 (One (1) missed dose) -Insulin Aspart Solution 5 units on 3/4/21 and 3/5/21 (Three (3) missed doses) -Metoprolol Tartrate 25 MG on 3/4/21 and 3/5/21 (Two (2) missed doses) -Furosemide Tablet 40 MG on 3/5/21, 3/22/21, 3/23/21, 3/29/21, 4/5/21 and 4/12/21 (Five (5) missed doses) -Isosorbide Mononitrate ER Tablet 60 MG on 3/11/21 (One (1) missed dose) -Insulin Glargine Solution Inject 60 units on 4/15/21 (One (1) missed dose) -Insulin Glargine Solution 15 units on 3/5/21 (One (1) missed dose) -Insulin Aspart Solution 5 units on 3/12/21 (One (1) missed dose) -Furosemide Tablet 20 MG on 3/23/21, 3/29/21 and 4/5/21 (Three (3) missed doses) -Clindamycin HCL Capsule 300 MG on 3/11/21 and 3/12/21 (Two (2) missed doses) -Levofloxacin Tablet 750 MG on 3/11/21 and 3/12/21 (Two (2) missed doses) -Levofloxacin in D5W 750 MG/ML on 4/12/21 (One (1) missed dose) -Cipro Tablet 500 MG on 4/8/21, 4/9/21 and	{F 760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 223 4/10/21 (Three (3) missed doses) -Ceftriaxone Sodium Solution 1 GM on 5/1/21 (One (1) missed dose) The total number of doses of significant medications that Resident #17 missed from March 1, 2021, to May 1, 2021, totaled 27. Record review revealed that Resident #17 did not receive his insulin and antibiotic therapy as ordered and likely contributed to worsening of the resident's wounds. Resident #7 Record review of the Admission Record revealed Resident #7 was initially admitted on 9/4/2018 and readmitted on 4/13/2021. Record review of Resident #7's Diagnosis Information included Type 2 Diabetes Mellitus, Heart Failure, Cardiomegaly, Cerebral Infarction, and Essential Hypertension. Record review of the Discharge Minimum Data Set (MDS) dated April 18, 2021, reveals that the Resident #7 has a Brief Interview for Mental Status (BIMS) score of 05, which indicates that Resident #7 is severely cognitively impaired. Record Review of Resident #7's Physician Orders revealed the following Physician Orders: 1. Xarelto Tablet 20 MG Give 1 tablet by mouth one time a day for Atrial Fibrillation with supper (Ordered 8/24/20) 2. Augmentin Tablet 875-125 MG Give 1 tablet by mouth two times a day for infection for 7 days. (Ordered 4/13/21)	{F 760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 224	{F 760}		

Review of Resident #7's MAR reveals that the resident did not receive the following dose(s) of ordered medication because it was unavailable:
-Xarelto on 3/9/21, 3/30/21, 3/31/21, 4/1/21, 4/13/21, 4/14/21, 4/15/21, and 4/17/21 (Eight (8) missed doses)
-Augmentin on 4/13/21 (One (1) missed dose)
The total number of doses of significant medications that Resident #7 missed from March 1 to April 30, 2021, totaled 9.
Review of Resident #7's Admission Record revealed that the resident has Atrial Fibrillation (a heart condition that can cause stroke or death).

Resident #10

Record review of the Admission Record revealed Resident #10 was admitted to the facility on 3/15/2021.
Record review of Resident #10's Diagnosis Information included Alcohol Dependence, Seizures, Stroke, Alcohol Abuse with Withdrawal, and Dementia.

Record review of the Admission Minimum Data Set (MDS) dated March 22, 2021 reveals Resident #10 has a Brief Interview for Mental Status (BIMS) score of 03, which indicates that Resident #10 is severely cognitively impaired.

Review of Resident #10's Physician orders revealed the following Physician orders:
1. Clopidogrel Bisulfate 75 mg by mouth one time a day related to stroke (Ordered 3/16/21)
2. Levetiracetam Solution 100 mg/milliliter (ML) by mouth two times a day related to seizures (Ordered 3/15/21)
3. Cyanocobalamin Tablet 1000 MCG give 1 tablet by mouth one time a day related to Alcohol

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 225 Dependence (Ordered 3/16/21) 4. Folic Acid Tablet 1 MG Give 1 Tablet by mouth one time a day related to Alcohol Dependence (Ordered 3/16/21) 5. Gabapentin Capsule 100 MG Give 1 capsule by mouth three times a day for Neuropathy (Ordered 3/15/21) 6. Thiamine HCL Tablet 100 MG Give 1 tablet by mouth one time a day related to Alcohol Dependence (Ordered 3/16/21) Review of Resident #10's MAR reveals that the resident did not receive the following dose (s) of medications because they were unavailable: -Clopidogrel Bisulfate on 3/16/21, 3/17/21, 3/31/21, 4/3/21, 4/4/21, 4/5/21, 4/6/21, 4/8/21, 4/9/21, 4/12/21, 4/13/21, 4/14/21, and 4/15/21 (13 missed doses) -Levetiracetam Solution one dose of the ordered medication on 3/16/21, 3/17/21, 4/2/21 and 4/19/21 (Four (4) missed doses) -Cyanocobalamin on 3/16/21, 3/17/21, 3/18/21, 3/22/21, 3/23/21, and 3/24/21 (Nine (9) missed doses) -Folic Acid on 3/16/17, 3/18/21, 4/3/21, 4/4/21, 4/5/21, 4/6/21, 4/8/21, 4/9/21, 4/12/21, 4/13/21, 4/14/21, and 4/15/21 (Ten (10) missed doses) -Gabapentin on 3/16/21, 3/17/21, 3/23/21, 4/1/21, 4/2/21, 4/3/21, 4/4/21, 4/5/21, 4/6/21, 4/7/21, 4/8/21, 4/8/21, 4/10/21, 4/11/21, 4/12/21, 4/13/21, 4/14/21 and 4/15/21 (41 missed doses) -Thiamine on 3/16/21, 3/17/21 and 4/2/21 (2 missed doses) The total number of doses of significant medications that Resident #10 missed from March 1 to April 30, 2021, totaled 79. Resident #11	{F 760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 226	{F 760}		

Record review of the Admission Record revealed Resident #11 was admitted to the facility on 12/15/2018.

Record review of Resident #11's Diagnosis Information included Type 2 Diabetes Mellitus, Seizures, Chronic Pancreatitis, Essential Hypertension, Vitamin B12 Deficiency Anemia, Recurrent Depressive Disorders, Bipolar Type Schizoaffective Disorder, and Chronic Obstructive Pulmonary Disorder.

Record review of the Quarterly Minimum Data Set (MDS) dated May 5, 2021, reveals that the Resident #11 has a Brief Interview for Mental Status (BIMS) score of 15, which indicates that Resident #11 is cognitively intact.

Record Review of the Physician orders revealed that Resident #11 had the following Physician Orders:
1. Amantadine HCL 100 mg by mouth two (2) times a day for Extrapyramidal Side Effects (Ordered 12/15/18)
2. Creon Delayed Release two (2) capsules by mouth before meals for Chronic Pancreatitis (Ordered 9/15/20)
3. Divalproex Sodium Delayed Release 500 mg by mouth two (2) times a day for convulsive disorder (Ordered 12/15/18)
4. Escitalopram Oxalate 20 mg by mouth a day for Depression (8/17/19)
5. Losartan Potassium 25 mg by mouth in the morning related to Essential (Primary) Hypertension (Ordered 7/6/20)
6. Metformin HCL 1000 mg by mouth two (2) days a day for Diabetes (Ordered 12/17/18)
7. Risperdal 2 mg by mouth two (2) times a day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 227 related to Bipolar Disorder (8/8/19) Review of Resident #11's MAR reveals that the resident did not receive the ordered medications on the following dates, as medication was unavailable: -Amantadine HCL on 3/1/2021, 3/2/2021, 3/4/2021, 3/8/2021, 3/9/2021, 3/10/2021, and 3/11/2021 (Seven (7) doses) -Creon on 3/29/2021 and 3/30/31 (Five (5) doses) -Divalproex Sodium on 3/1/2021, 3/2/21021, 3/4/2021, 3/8/2021, 3/9/2021, 3/10/2021, 3/11/2021 4/14/2021 (Nine (9) doses) -Escitalopram Oxalate on 3/1/2021, 3/2/2021, 3/4/2021, 3/8/2021, 3/9/2021, 3/10/2021, and 3/11/2021 (Seven (7) doses) -Losartan Potassium on 3/1/2021, 3/2/2021, 3/4/2021, 3/8/2021, 3/9/2021, 3/10/2021, and 3/11/2021 (Seven (7) doses) -Metformin on 3/1/2021, 3/2/2021, 3/3/2021, 3/4/2021, 3/8/2021, 3/9/2021, 3/10/2021 and 3/11/2021 (Nine (9) doses) -Risperdal on 3/1/2021, 3/2/2021, 3/3/2021, 3/5/2021, 3/8/2021, 3/9/2021, 3/10/2021 and 3/11/2021 (13 doses) The total number of missed doses of significant medications that Resident #11 missed from March 1 to April 30, 2021, totaled 57. On 5/6/2021 at 9:40 AM, an interview with Resident #11, revealed that the resident states that her medications are not always available. She stated that this happens almost monthly and that she remembers not getting her Metformin for three (3) consecutive days. Resident #8	{F 760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 228	{F 760}		

Record review of the Admission Record revealed Resident #8 was initially admitted to the facility on 8/8/2019 and readmitted on 11/28/2020.

Record review of the Quarterly Minimum Data Set (MDS) dated April 13, 2021, revealed that Resident #8 has a Brief Interview for Mental Status (BIMS) score of 13, which indicates that Resident #8 is cognitively intact.

Record review of Resident #8's Diagnosis Information included, Type 2 Diabetes Mellitus, Congestive Heart Failure, Cerebral Vascular Accident, Encephalopathy, Local Infection of the Skin and Subcutaneous Tissue, and Recurrent Major Depression Disorder.

Physician orders reveals that Resident #8 had the following Physician Orders:
1. Chewable Aspirin Tablet 81 mg by mouth one time a day related to Congestive Heart Failure (Ordered 8/7/19)
2. Carvedilol Tablet 6.25 mg by mouth two (2) times a day related to Essential Hypertension (Ordered 8/7/19)
3. Clopidogrel Bisulfate 75 mg by mouth one (1) time a day for blood clot prevention (Ordered 8/7/19)
4. Escitalopram Oxalate 20 mg by mouth one time a day for Depression (Ordered 8/7/19)
5. Jardiance 25 mg by mouth one (1) time a day related to Type 2 Diabetes Mellitus (Ordered 4/7/20)
6. Lantus Solution 100 unit/mL 30 units subcutaneously one (1) time a day related to Type 2 Diabetes Mellitus (Ordered 8/20/20)
7. Losartan Potassium Tablet 25 MG Give 1 tablet by mouth one time day related to Essential Hypertension (Ordered 1/27/20)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 229 8. Metformin HCL Extended Release give 500 mg by mouth one (1) time a day related to Type 2 Diabetes Mellitus (Ordered 4/7/20) 9. Bactrim DS 800-180 mg by mouth two times a day for infection to left great toe for ten (10) days (Ordered 2/23/21) Review of Resident #8's MAR reveals that the resident did not receive the ordered medications on the following dates, as the medication was unavailable: -Aspirin on 3/1/2021, 3/2/2021, 3/4/2021, 3/5/2021, 3/10/2021, and 3/11/2021 (Six (6) missed doses) -Carvedilol on 3/1/2021, 3/4/2021, 3/5/2021, and 3/10/2021 (Four (4) missed doses) -Clopidogrel Sulfate on 3/1/2021, 3/2/2021, 3/4/2021, 3/5/2021, 3/5/2021, 3/9/2021, and 3/10/2021 (Seven (7) missed doses) -Escitalopram Oxalate on 3/1/2021, 3/2/2021, 3/4/2021, 3/5/2021, 3/10/2021, and 3/11/2021 (Six (6) missed doses) -Jardiance on 3/1/2021, 3/2/2021, 3/4/2021, 3/5/2021, 3/10/2021, and 3/11/2021 (Six (6) missed doses) -Lantus on 3/1/2021, 3/2/2021, 3/4/2021, 3/5/2021, 3/10/2021, and 3/11/2021 (Six (6) missed doses) -Losartan Potassium on 3/1/2021, 3/2/2021, 3/4/2021, 3/5/2021, 3/7/2021, 3/10/2021, and 3/11/2021 (Seven (7) missed doses) -Metformin on 3/1/2021, 3/4/2021, 3/5/2021, and 3/9/2021 (Four (4) missed doses) -Bactrim DS on 3/1/21, 3/4/21 and 3/5/21 (Three (3) missed doses) The total number of doses of significant medications that Resident #8 missed from March 1 to April 30, 2021, totaled 49.	{F 760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 230	{F 760}		

Resident #16

Record review the Admission Record reveals Resident #16 was admitted to the facility on 2/26/21 and readmitted to the facility on 4/16/21.

Record review of Resident #16's Diagnosis Information include Schizophrenia, Seizures, Essential Hypertension, and Cellulitis of Left Lower Limb.

Record review of the admission Minimum Data Set with an assessment reference date of 4/21/21 revealed Resident #16 had a Brief Interview of Mental Status score of 14 indicating that the resident was cognitively intact.

Record Review of the Physician orders reveals that Resident #16 had the following Physician Orders:
1. Amlodipine Besylate 10 MG give 1 tablet by mouth one time a day related to Essential Hypertension (Ordered 2/26/21)
2. Furosemide 20 MG give 1 tablet by mouth one time a day related to Edema (Ordered 2/26/21)
3. Lisinopril 10 MG give 1 tablet by mouth one time day related to Essential Hypertension (Ordered 2/26/21)
4. Levetiracetam 250 MG give 1 tablet by mouth one time a day related Seizures (Ordered 2/26/21)
5. Metoprolol Tartrate 50 MG give 1 tablet by mouth two times a day related to Essential Hypertension (Ordered 2/26/21)
6. Haldol Solution 5 MG/ML Inject 5 m intramuscularly every 6 hours related to Restlessness and agitation (Ordered 2/26/21)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 231 7. Quetiapine Fumarate 100 MG give 2 tablets by mouth two times a day related to Schizophrenia (Ordered 4/16/21) 8. Fluoxetine HCL 10 MG give 1 tablet by mouth one time a day related to Schizophrenia (Ordered 4/16/21) 9. Divalproex Sodium Tablet Delayed Release 500 MG Give 1 tablet by mouth one time a day related to Seizures (Ordered 4/17/21) 10. Bactrim DS 800-160 MG give 1 tablet by mouth two times a day for cellulitis (Ordered 4/27/21) 11. Haldol Tablet 10 MG Give 1 tablet by mouth two times a day for Agitation Review of Resident #16's MAR reveals that the resident did not receive the ordered medications on the following dates, as the medication was unavailable: -Amlodipine Besylate on 3/1/21 and 4/16/21 (Two (2) missed doses) -Furosemide on 3/1/21, 3/2/21 and 4/16/21 (three (3) missed doses) -Lisinopril on 3/1/21, 3/2/21, and 4/16/21 (Three (3) missed doses) -Levetiracetam on 3/2/21, 4/16/21, 4/26/21 and 4/27/21 (Four (4) missed doses) -Metoprolol on 3/1/21, 3/2/21, 4/16/21, 4/26/21 and 4/27/21 (Seven (7) missed doses) -Quetiapine Fumarate on 3/1/21, 3/2/21, 4/16/21, 4/17/21 and 4/18/21 (Four (4) missed doses) -Fluoxetine on 4/17/21 (One (1) missed dose) -Divalproex Sodium on 4/17/21 and 4/19/21 (Two (2) missed doses) -Bactrim DS on 4/27/21, 4/28/2/1 and 4/30/21 (Three (3) missed doses) -Haldol Solution on 5/2/21, 5/3/21, 5/4/21, 5/5/21 and 5/6/21 (15 missed doses) -Haldol Tablet on 5/6/21 (One (1) missed dose)	{F 760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 232	{F 760}		

The total number of doses of significant medications that Resident #16 missed from March 1 to May 9, 2021, totaled 45.

Resident # 1

Record review of Resident #1's Admission Record revealed Resident #1 was admitted to the facility on 3/17/2021.

Record review of Resident #1 Diagnosis Information included Unspecified Dementia with Behavioral Disturbance, Epilepsy, Cognitive Communication Deficit, Generalized Anxiety Disorder, Mood Disorder with Known Physiological Condition with Manic Features, Hypothyroidism, and Angina Pectoris.

Record review of the Admission Minimum Data Set (MDS) dated 3/23/2021, revealed a Brief Interview of Mental Status (BIMS) score of 00, indicating that Resident #1 has severe impairment in cognition.

Record Review revealed that Resident #1 had the following Physician Orders:
1. Quetiapine Fumarate Tablet 25 MG Give 1 tablet by mouth at bedtime for Dementia (Ordered 3/25/21)
2. Aricept Tablet 10 MG Give 1 tablet by mouth at bedtime for Dementia (Ordered 4/30/21)
3. Seroquel Tablet 300 MG Give 300 mg by mouth at bedtime for Dementia with Behavioral problems related to Mood Disorder due to known physiological condition with manic features. (Ordered 4/30/21)
4. Alprazolam Tablet 1 MG Give 1 tablet by mouth two times a day for Agitation and Anxiety

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 233 (Ordered 4/5/21) 5. Divalproex Solution Tablet Delayed Release 250 MG Give 1 tablet by mouth two times a day related to Epilepsy (Ordered 4/30/21) 6. Namenda Tablet 5 MG Give 1 tablet by mouth two times a day related to unspecified Dementia with Behavioral Disturbance (Ordered 4/30/21) 8. Olanzapine Tablet 10 MG Give 1 tablet by mouth three times a day related to Mood Disorder due to known physiological condition with Manic Features (Ordered 4/30/21) 9. Alprazolam Tablet 0.5 MG Give 1 tablet by mouth one time a day related to Generalized Anxiety Disorder (Ordered 5/1/21) 10. Prednisone Tablet 10 MG Give 1 tablet by mouth one time a day for right foot pain for 5 days (Ordered 5/2/2021) Review of Resident #1's MAR reveals that the resident did not receive the ordered medications on the following dates, as the medication was unavailable: -Quetiapine Fumarate on 3/27/21 and 4/30/21 (Two (2) doses missed) -Aricept on 4/30/221 ((One (1) dosed missed) -Seroquel on 4/30/21 (One (1) dose missed) -Alprazolam on 5/5/21 and 5/6/21 (Two (2) missed doses) -Divalproex on 4/30/21, 5/5/21 and 5/6/21 (Three (3) missed doses) -Namenda on 4/30/21 (One (1) dose missed) -Olanzapine on 5/5/21 and 5/6/21 (Four (4) doses missed) -Alprazolam on 5/5/21 and 5/6/21 (Two (2) doses missed) -Prednisone on 5/2/21, 5/5/21 and 5/6/21 (Three (3) doses missed) The total number of doses of significant	{F 760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 234	{F 760}		

medications that Resident #1 missed from March 17 to May 7, 2021, totaled 19.

Resident #2

Record review of the Admission Record revealed Resident #2 was admitted to the facility on 6/19/2020.

Record review of Resident #2's Diagnosis Information included Type 2 Diabetes Mellitus, Chronic Embolism with Thrombosis, Unspecified Fracture of Shaft of Left Fibula, Atherosclerotic Heart Disease, Pressure Ulcer of Sacral Region, and Chronic Kidney Disease.

Record review of Resident #2's Quarterly Minimum Data Set (MDS) dated 3/9/2021, reveals a Brief Interview for Mental Status (BIMS) score of 07. A BIMS score of 07 indicates Resident #2 is severely cognitively impaired.

Record Review of the Physician orders reveals that Resident #2 had the following Physician Orders:
1. Eliquis 5 MG Give 5 mg by mouth two (2) times a day for anticoagulant (Ordered 6/18/20)
Review of Resident #2's MAR reveals that the resident did not receive the ordered dose (s) of Eliquis 3/1/21 (One (1) dose missed), 3/2/21 (One (1) dose missed), 3/4/21 (One (1) missed dose), 3/5/21 (One (1) missed dose), 3/8/21 (Two (2) missed doses), 3/9/21 Two (2) missed doses), 3/10/21 (One (1) missed dose), 3/18/21 (One (1) missed dose), 3/19/21 (One (1) missed dose) , 3/22/21 (One (1) missed dose), 3/23/21 (One (1) missed dose), 4/8/21 (Two (2) missed doses), 4/9/21 (Two (2) missed doses), 4/10/21 (One (1) missed dose), 4/12/21 (Two (2) missed doses)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 235	{F 760}		

and 4/13/21 (Two (2) missed doses), as the medication was unavailable.

The total number of doses of significant medications that Resident #2 missed from March 1 to April 30, 2021, totaled 22.

Resident #9

Record review of the Admission Record revealed Resident #9 was originally admitted on 10/16/2020 and re-admitted on 2/11/2021.

Record review of Resident #9's Diagnosis Information included Type 2 Diabetes Mellitus, Essential Hypertension, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Peripheral Vascular Disease, and Cerebral Infarction.

Record review of the Quarterly Minimum Data Set (MDS) dated April 8, 2021 revealed that the resident has a Brief Interview for Mental Status (BIMS) score of 15, which indicates that the resident is cognitively intact.

Review of Resident #9's Physician Orders reveal orders for:
1. Aspirin EC Tablet Delayed Release 81 MG Give 1 tablet by mouth one time a day for Cerebrovascular Accident (CVA) (Ordered 10/20/20)
2. Amlodipine Besylate Tablet to MG Give 1 tablet by mouth one time a day for Essential Hypertension (Ordered 11/3/20)
3. Potassium Chloride ER Tablet Extended Release 20 MEQ Give on tablet by mouth one time a day for diuretic use (Ordered 1/12/21)
4. Losartan Potassium Tablet 50 MG Give 50 mg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 236	{F 760}		

by mouth in the morning for Hypertension (Ordered 1/15/21)
5. Furosemide Tablet 40 MG Give 1 tablet by mouth in the morning for Hypertension/Edema related to Essential Hypertension (Ordered 1/26/21)
6. Humulin 70/30 Suspension 100Unit/ML Inject 50 units subcutaneously two times a day related to Type 2 Diabetes Mellitus (Ordered 2/11/21)

Review of Resident #9's's MAR reveals that the resident did not receive the ordered medications on the following dates, as the medication was unavailable:
-Aspirin EC Tablet on 3/1/21 and 3/9/21 (Two (2) doses missed)
-Amlodipine Besylate on 3/1/21 and 3/9/21 (Two (2) doses missed)
-Potassium Chloride ER on 3/4/21, 3/8/21 and 3/9/21 (Three (3) doses missed)
-Losartan Potassium on 3/1/21 and 3/8/21 (Two (2) doses missed)
-Furosemide on 3/1/21, 3/4/21, 3/8/21 and 3/10/21 (Four (4) doses missed)
-Humulin 70/20 on 3/1/21, 3/8/21 and 3/10/21 (Three (3) doses missed)
The total number of doses significant medications that Resident #9 missed from March 1 to April 30, 2021, totaled 16.

Resident #15

Record review of the Admission Record revealed Resident #15 was admitted to the facility on 11/25/2020.

Record review of Resident #15's Diagnosis Information included Chronic Pain Syndrome, Type 2 Diabetes Mellitus, Essential Hypertension,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 237	{F 760}		

and Hypertensive Heart Disease.

Record review of Resident #15's Quarterly Minimum Data Set (MDS) dated 2/25/2021, revealed a Brief Interview for Mental Status (BIMS) score of 12 indicating Resident #15 is moderately cognitively impaired.

Review of Resident #15's Physician Orders revealed that the Physician Orders include orders for Lyrica 100 mg by mouth three (3) times a day related to Muscle Spasm of Back.

Review of the Resident #15's MAR reveals that the resident did not receive the ordered medicine on 3/9/19 (Two (2) doses missed), 3/18/21 (Two (2) doses missed) and 4/6/21 (Three (3) doses missed) because it was unavailable.

The total number of doses of significant medications that Resident #10 missed from March 1 to April 30, 2021, totaled 7.

Removal Plan:
The ADON/ICC was in-serviced regarding the process of obtaining medications from the pharmacy, including the back-up pharmacy process, on 5/22/2021 by the Regional Nurse Consultant. The ADON/ICC initiated education on obtaining medications from the pharmacy, the back-up pharmacy process, and completing match backs daily for all nurses on 5/22/2021. Beginning 5/24/2021 through 6/12/21, the ADON/ICC, Staff Educator, MDS Coordinator, and Regional Nurse Consultant conducted multiple in-services with nursing employees (RNs, LPNs) regarding documentation of medication, specifically omission or not documented medications. Any staff missing in-services will not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 238	{F 760}		

work until they receive the education. Any staff member who fails to comply with the direction of the in-services will be further educated and/or progressively disciplined.
The Medical Record's Manager, Assistant Director of Nursing/ICC, and the Director of Nursing completed a match back for Residents #2, #7, #8, #9, #10, #11, #15, and #17 on 5/21/21 to ensure that all medications were available as ordered. Any medications noted as unavailable were ordered from the pharmacy and were obtained on 5/22/21.
The attending physician was notified of the missed medications on 5/25/2021 by Medical Records with no new orders at that time Residents #2, #7, #8, #9, #10, #11, #15, and #17.
On 6/01/21, the Owner sent a letter of termination of services to the current Pharmacy Service; a new company will take over in 30 days. There will be no lapse in coverage.
Validation:
The State Survey Agency (SSA) validated through interview the Assistant Director of Nursing/Infection Control Coordinator (ADON/ICC) was in-serviced by the Regional Nurse Consultant on the process of obtaining medications from the pharmacy, including the back-up pharmacy process.

The SSA validated through interviews and in-service sign in sheets the ADON/ICC provided education to all licensed nurses on obtaining medications from the pharmacy, the back-up pharmacy process, and completing match backs daily.

The SSA validated through interviews and in-service sign-in sheets that multiple in-services were conducted by the ADON/ICC, Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 760}	Continued From page 239 Educator, MDS Coordinator, and Regional Nurse Consultant with licensed nurses regarding documentation of medication, specifically omission or not documented medications. The nursing staff verified that they were required to attend the in-services before they were allowed to work. The ADON verified all licensed staff have complied with the direction of the in-services. The SSA validated through interview with ADON/ICC that match backs were completed to ensure medications were available for the eight (8) residents remaining in the facility that were cited for not receiving signification medications. The SSA validated through interview with the attending physician that he had been notified of missed medications. The SSA validated through interview and letter review that on 6/01/21, the Owner sent a letter to the current Pharmacy stating the Pharmacy had defaulted under the terms of the contract.	{F 760}		
{F 835} SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, job description review, and plan of correction review from 12/04/20, the facility's Administration failed to (1) ensure the facility used its resources effectively, to sustain compliance for staffing to	{F 835}	1. On 5/6/21, the Regional Director of Operations issued a written corrective action to the Administrator regarding abuse and neglect, including the failure to report alleged violations. Effective	7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 835}	Continued From page 240 ensure adequate care of residents' needs; (2) implement abuse policies and procedures by recognizing escalating behaviors for prevention of resident to resident abuse and protection of residents; (3) report potential and actual abuse to State Survey Agency and local authorities; (4) ensure care of resident needs to prevent development and worsening of pressure ulcers; (5) ensure medications were available and administered to residents routinely and timely for 24 of 24 residents out of a total of 65 residents. The facility's failure to have effective administrative oversight, implementation, and monitoring of its resources resulted in a situation that is likely to cause serious injury, impairment, harm, or death to residents. This situation resulted in an Immediate Jeopardy, and the State Agency identified the Immediate Jeopardy (IJ) on 5/21/21. The IJ was determined to exist on 11/17/21, when medications were not available as ordered, and the IJ was not removed prior to exit on 05/26/21 and is considered ongoing. The IJ existed at CFR §483.70 Administration. The IJ was not removed prior to the State Agency (SA) exit on 5/26/2021 and was considered ongoing. The facility provided a Credible Removal Plan, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy.	{F 835}	5/26/21, the Regional Director of Operations was terminated. A new Regional Director of Operations has been hired with a start date of 07/01/21. Effective 5/26/21, the Senior Director of Operations, Region 2 Regional Director of Operations and/or the Owner provided direct oversight of the former Administrator until the new Administrator began on 06/21/21. Effective 6/12/21, the Facility□s Director of Nursing was terminated from her position and an interim Director of Nursing was appointed. There was no lapse in coverage of an Administrator. The Senior Director of Operations and Region 2 Regional Director of Operations provided oversight in the changing of Administrators to ensure a smooth transition, continuity of care. 2. All residents have the potential to be affected by the deficit practice cited. 3. New Administrator started 6/21/21. New regional director of operations started 7/1/21. Interim DON in place and new DON hired will begin 7/21/21. 4. Beginning 6/29/21 Administrative oversight log will be utilized to document administrative oversite daily by the Administrator or Administrator in training. Findings will be brought to Quality Assurance Performance Improvement monthly beginning 7/2/21 for review, revision, or resolution of the plan for six months. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance. The Administrator will report to the Governing Body and Management	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 835}	Continued From page 241 The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interviews and in-service sign-in sheets review. The facility provided evidence the facility had implemented corrective actions listed in the Credible Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for CFR §483.70 has been lowered from the scope and severity of a "L" to the scope and severity of an "F". The facility will remain out of compliance at Scope and Severity of "F" that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: A review of the job description entitled "Nursing Home Administrator (NHA)" documented, "As Nursing Home Administrator, you will be responsible for the overall operations, leadership' management, and success of the facility in accordance with resident/employee needs, government, regulations, and company policy. Responsible for financial management, quality assurance, regulatory management, business development goals and maximization of revenue, family relations, and resident care. In addition, responsible for attracting and retaining top performing talented team members as well as the supervision and career coaching team members on staff. Essential duties of the Administrator include:	{F 835}	Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

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	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

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{F 835}	Continued From page 242	{F 835}		

direct and coordinate medical, nursing, and administrative staffs and services; implements and coordinates policies and procedures for various departments, conducts regular rounds to monitor delivery of nursing care and operation of support departments; ensures consultants and other support resources are appropriately utilized; direct hiring and training of personnel, oversees Quality Assurance and Performance Improvement (QAPI) standards; maintains working knowledge of governmental regulations."

Review of the Administrator's license revealed the licensure was issued on April 1, 2021. The previous Administrator had resigned.

On 05/20/21 at 2:00 PM, an interview with the Administrator revealed he reports to the Regional Corporate Operations Manager who develops policies. The Administrator stated it is the responsibility of the Administrator to make sure the policies are followed. The Administrator stated he is responsible for writing the Facility Assessment; however, the Administrator confirmed the facility's current assessment is not sufficient to meet the needs of the residents in this building. The Administrator confirmed the assessment does not give guidance on staffing, wound care and lifts.

The Administrator stated that he would need to make some corrections to the Facility Assessment. The Administrator explained the Department heads meet every morning to discuss issues, concerns, and deficient practice in the facility and the QAPI team meets monthly to discuss high risk issues. He confirmed that he should have known the facility did not have sufficient/competent staff to take care of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 835}	Continued From page 243	{F 835}		

needs of the residents.

The Administrator said that during the last QAPI meeting in April the team discussed that some medications were not given as ordered. The plan from QAPI was for the DON to call the pharmacy when a medication was not available. The Administrator also said the QAPI team discussed the wound care assessment documentation not being done. The plan again was for the DON to assess all the wounds and put documentation in the resident's charts.

The Administrator confirmed the facility has system failures with the wound care, staffing and medication administration. The Administrator also confirmed he failed to report the resident-to-resident abuse incidents. The Administrator said he previously worked in Louisiana and was told that in Louisiana it was not required to report verbal abuse. He denied being aware a resident was hit, and hair was pulled until the State Agency investigated the complaint. The Administrator confirmed he did not talk to the resident until after the SA interviewed the resident. The Administrator also confirmed he did not report a suspicious fracture. The Administrator said he put it on his calendar to remember to send in the investigation, but he forgot. The administrator said he received a copy of the resident X-ray reports and noted he had a fracture to the tibia.

In the interview continued on 05/20/21 at 2:00 PM, the Administrator confirmed the facility should have known they did not have sufficient/competent staff to take care of the needs of the residents. The Administrator said he thought it was okay to piece the schedule

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

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LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 835}	Continued From page 244	{F 835}		

together. He said he let some Certified Nurse Aides work 2 or 3 hour shifts to make up for the shortage.

The Regional Director of Operations (RDO) stated the Administrator is responsible for having an appropriate facility assessment. The RDO confirmed the facility was aware of the problem with getting the resident's medications, but the facility has a back-up pharmacy. The RDO stated deficient practice started from the COVID-19 pandemic with the prior DON because the facility did not have enough staff.

An interview on 05/20/21 at 12:30 PM with a facility physician said she had met with the Administrator and Director of Nursing (DON) about her concerns several times and reported several issues in December about low staffing and medication problems. The Physician stated the Administrator stated that the facility had a contract with the local pharmacy to receive three to seven days' worth of medication until the routine medication came in. The Administrator said the facility was going to bring in agency staff.

Review of the 2567 and Plan of correction from survey on 12/04/20 with a completion date of 01/26/21 revealed the facility had failed to follow the plan of correction related to cited staffing deficiencies. The plan of correction read:
1. State Agency entered building on 12/2/2020, facility was notified on 12/04/2020 that there was not sufficient staff for 12/02/2020. When next notified of possible staffing shortage on December 11th, 12th and 13th, Director of Nursing (DON) called Administrator who called Regional Director of Operations. All employees on call sheet were called. Staffing agency was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 835}	Continued From page 245	{F 835}		

called on December 11th to provide coverage. Staffing agency was able to provide coverage and facility agreed to guarantee two nurses and two certified nursing assistants (C.N.A.) slots for the next two weeks and pay hazard pay. Agency was able to provide needed employees.
2. All residents have the potential to be affected by this deficient practice.
3. Nurses were in-serviced on staffing on December 14,2020 by Administrator, Quality Assurance and Performance Improvement plan was completed December 14, 2020 by the Administrator. System changes put into place to ensure the problem does not recur include computerized schedules, proper use of daily staffing sheets, and review of staffing in department head meeting. Charge nurses for each shift will notify DON via facility cell phone if sufficient staffing is not in place or call-ins or no-shows occur. Charge nurse for each shift will text DON number of nurses and C.N.A.s so that we may ensure adequate staffing, DON will log calls on call log sheet.
4. Staffing schedules have been placed into Smartlinx on December 23. Assistant Director of Nursing (ADON) started completing daily staffing sheets on December 14 and went back to December 5, ADON will turn in staffing sheets to Administrator. ADON will spot check staffing 3 times per week for 6 weeks then as needed and will document on Staffing Reconciliation Sheet. Administrator will confirm staffing and sign off on sheets. Facility will monitor its performance to ensure solutions are sustained by computing daily required nursing hours to ensure above standard of 2.8. Finding will be presented to Quality Assurance Committee (QA) who will review and make recommendations regarding staffing. QA committee will review monthly for 3 months then

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	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

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{F 835}	Continued From page 246 as needed. Interview on 05/25/21 at 12:32 PM with the Assistant Director of Nursing (ADON) revealed as soon as the facility achieved compliance from the 12/04/20 survey deficiency, the facility pulled out the agency staff. She stated the facility has been short ever since. Removal Plan: On 5/6/21, the Regional Director of Operations issued a written corrective action to the Administrator regarding abuse and neglect, including the failure to report alleged violations. Effective 5/26/21, the Regional Director of Operations was terminated and the Senior Director of Operations currently seeking to hire a replacement. Effective 5/26/21, the Senior Director of Operations and/or the Owner has provided direct oversight of the current Administrator. Effective 6/10/21, the Facility's Director of Nursing was terminated from her position and an interim Director of Nursing was appointed. A new Administrator was hired with a committed start date of 6/21/21 to replace the current Administrator. There will be no lapse in coverage of an Administrator. The Senior Director of Operations will provide oversight in the changing of Administrators to ensure a smooth transition, continuity of care, and is scheduled to orient the new Administrator on all action plans to resolve the deficiencies cited in the recent survey. Validation: The SA validated through review of written disciplinary corrective action to the Administrator by the Regional Director of Operations. regarding abuse and neglect, including failure to report alleged violations.	{F 835}		

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	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 835}	Continued From page 247 The SA validated through an interview with the Senior Director of Operations the Regional Director of Operations was terminated. The SA validated through interviews with the Senior Director of Operations, direct oversight of the current administrator has been provided by the Regional Director of Operations, the Senior Director of Operations, and the Owner. The SA validated through interviews and record review of the termination report, the DON was terminated, and the facility has an interim DON on staff. The SA validated through staff interviews a new administrator has been hired and the Senior Director of Operations verified the new administrator will start on 6/21/21.	{F 835}		
{F 837} SS=F	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on an interview the governing body failed to act on information reported by the facility's	{F 837}	1. During the 5/25/21 Quality Assurance Performance Improvement Committee	7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 837}	Continued From page 248 management regarding operation of the facility. The governing body failed to provide oversight for the facility's Quality Assurance Performance Improvement (QAPI) program and related facility concerns. The governing body failed to hold the Administrator accountable for the safe daily operations of the facility. This had the potential to affect 65 of 65 residents in the facility. The facility's failure to act on reported information by the facility's management regarding operation of the facility and failure to be accountable, engaged, and involved for the implementation of facility policies and management of the facility, put all residents residing in the facility at risk for serious harm, serious injury, serious impairment, or possible death. This failure resulted in worsening pressure ulcers, missed significant medications, abuse and failure to provide sufficient and competent staff, failure to provide behavioral health services and competent staff for behavioral health needs, and failed to have an effective QAPI program. The situation was determined to be an Immediate Jeopardy (IJ) which began on 11/17/2020 after the SA entered the facility and identified the failure of the facility's governing body to act on reported information by the facility's management regarding operation of the facility to decrease the likelihood of serious injury, harm, impairment, or death. The IJ existed at §483.70(d§483.70(d)(2) §483.70(d)(3) Governing body. The IJ was not removed prior to the State Agency (SA) exit on 5/26/2021 and was considered	{F 837}	Meeting, the Senior Director of Clinical Services and Owner/Managing Member educated the QAPI Committee on the QAPI Committee process and the revised agenda. The Senior Director of Clinical Services and Owner/Management Member also introduced the necessary audits with corresponding calendars and revised trending tools. QAPI Committee members included the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing/Infection Control Coordinator, Dietary Manager, Business Office Manager/Human Resources, Life Connections, Housekeeping Supervisor, Admissions Coordinator, Minimum Data Set Coordinator, Rehabilitation Director, Lead Certified Nursing Assistant, Maintenance Supervisor, and Medical Records. The Owner and Senior Director of Clinical Services, as members of the Governing Body, provided education to the QAPI Committee regarding the need to participate regularly in QAPI process, need to identify Root Causes. The Governing Body and the Facility Management team changed the Medical Director of the Facility. The new Medical Director officially accepted the role and responsibilities of the Medical Director as of 5/26/2021 and began work on 5/26/2021. The Owner provided education to the new Medical Director on the responsibilities and status of the Facility on 5/25/2021. 2. All residents have the potential to be affected by the deficit practice cited. 3. Beginning 6/01/21 the Administrator	

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	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

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{F 837}	Continued From page 249 ongoing. The facility provided a Credible Removal Plan, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interviews and in-service sign-in sheets review. The facility provided evidence the facility had implemented corrective actions listed in the Credible Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for §483.70(d§483.70(d)(2) §483.70(d)(3) has been lowered from the scope and severity of a "L" to the scope and severity of an "F". The facility will remain out of compliance at Scope and Severity of "F" that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: On 5/20/21 at 10:00 AM, an interview with the Regional Director of Operations (RDO) revealed the owner of the facility would be considered the Governing Body. The RDO stated the facility does not have a policy that addresses the Governing Body.	{F 837}	presents the QAPI meeting minutes and reports to the Governing Body monthly for review. The Governing Body will evaluate and provide feedback to Administrator. On 6/03/21 a conference call was held among the Owner, Director of Operations, and Director of Clinical Services to review the following: 1) the outcomes of the survey; 2) expectations and roles of the Governing Body as outlined in the Rules and Regulations; and 3) the development of a plan for the following communication/monitoring tools: caring for pressure wounds, ensuring effective pharmacy services and reducing medication issues, dealing with abuse and neglect effectively, ensuring sufficient and competent staff, providing behavioral health services, and providing a functioning QAPI Committee. The Owner requested the assistance of the Corporate Team and the Independent Consultant to conduct root cause analyses of these failures and to deliver a Corrective Action plan for improvement for the Governing Body□s oversight. 4. QAPI meetings have been scheduled on the facility calendar every other week monthly beginning 7/2/21 times two months. A schedule was created to bring audit findings to QAPI meetings. Findings will be brought to QAPI monthly for review, revision, or resolution of the plan. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance. The Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis	

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	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 837}	Continued From page 250 On 05/20/21 at 2:00 PM, an interview with the Administrator revealed the owner is the governing body. The Administrator stated that he reports to the Regional Corporate Operations Manager. The Administrator stated the facility's policies are developed by the corporate department. The Administrator stated it is his responsibility to make sure the policies are followed. On 5/20/21 at 2:30 PM, an interview with the owner confirmed he is the governing body. The owner stated he appoints the Administrator, and that the Administrator reports directly to him. The owner stated he is a part of the Quality Assurance Performance Improvement (QAPI) program and that any QAPI issues are brought to him through emails, phone calls or fax by the Administrator. He stated he does not have a particular process to receive the QAPI information. The owner stated the pharmacy was changed during the summer last year. The owner stated he was aware of the issues with the medications, staffing, residents being admitted with behaviors and wound issues. He stated he did not know how severe it was and that all this was an eye opener to him. The owner confirmed his QAPI program failed but he did not know where the failure began and with whom. Removal Plan: On 5/24/2021 during the QAPI Committee Meetings, the Senior Director of Clinical Services and Owner/Managing Member educated the QAPI Committee on the QAPI Committee process and the revised agenda. The Senior Director of Clinical Services and Owner/Management Member also introduced the	{F 837}	beginning 7/1/21 for six months.	

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	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

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{F 837}	Continued From page 251	{F 837}		

necessary audits with corresponding calendars and revised trending tools. QAPI Committee members included the Administrator, DON, Medical Director, ADON/ICC, Dietary Manager, BOM/HR, Life Connections, Housekeeping Supervisor, Admissions Coordinator, MDS Coordinator, Rehabilitation Director, Lead Certified Nursing Assistant, Maintenance Supervisor, and Medical Records.
The Owner and Senior Director of Clinical Services, as members of the Governing Body, provided education on 5/24/21 to the QAPI Committee regarding the need to participate regularly in QAPI process, need to identify Root Causes.
The Governing Body and the Facility Management team changed the Medical Director of the Facility. The new Medical Director officially accepted the role and responsibilities of the Medical Director as of 5/26/2021 and began work on
5/26/2021. The Owner provided education to the new Medical Director on the responsibilities and status of the Facility on 5/25/2021.
Validation:
The SA validated through Department Head interviews and reviews of the Quality Assurance and Performance Improvement (QAPI) sign in sheets, the facility held a QAPI meeting on 5/24/21. Interviews with department heads verified the QAPI meeting was held, and the committee received education on the QAPI process and revised agenda. The Senior Director of Clinical Services verified she introduced possible auditing processes, calendars, and trending tools that can be utilized for the QAPI process.
The SA validated through in-service sign in sheets and an interview with the Senior Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 837}	Continued From page 252 of Clinical Services, the Owner and the Senior Director of Clinical Services provided education to the QAPI committee regarding the need to participate regularly in the QAPI process and the need to identify root cause analysis of issues identified at QAPI meetings. The SA validated through interview and record review, the Owner provided education on the responsibilities of the Medical Director and status of the facility regarding survey findings to the new Medical Director on 5/25/21. The SA validated through interview and contract review, the new Medical Director signed a contract and officially accepted the role and responsibilities of the Medical Director on 5/26/21.	{F 837}		
{F 838} SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population	{F 838}		7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 838}	Continued From page 253	{F 838}		

considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 838}	Continued From page 254 all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to develop a facility assessment to determine resources needed to competently care for the residents who resided in the facility. This failure resulted in non-compliance related to wounds not being assessed, medications not available for administration, not providing behavioral health services, failure to protect residents from abuse and neglect, and sufficient staff not available to care for residents. This had the potential to affect 65 of 65 residents in the facility. The facility failed to provide a policy or procedure on the development and implementation and utilization of the facility assessment. The facility's failure to evaluate the Resident population and identify the resources needed to provide the necessary care and services was likely to cause all residents residing in the facility serious harm, serious injury, serious impairment, or possible death. Serious outcomes related to the failure included worsening wounds, missed medications, unidentified and treated behaviors, and abuse and neglect. The situation was determined to be an Immediate Jeopardy (IJ) on 5/21/21 and was determined to exist 11/17/2020 after the SA entered the facility and identified the failure of the facility to develop a facility assessment to determine resources needed to competently care for the residents who resided in the facility to decrease the likelihood of serious injury, harm, impairment, or death.	{F 838}	1. On 5/6/21, the Regional Director of Operations issued a written corrective action to the Administrator regarding the development of an effective Facility Assessment. On 6/1/21, the Senior Director of Operations and other corporate staff assisted the Administrator in the revision of the Facility Assessment to provide for an evaluation of the resident population, identify the resources needed to provide the necessary competent staff, and guide the facility on staffing and how to meet the needs of the residents to ensure the person-centered care and services that the residents require. On 6/4/21, the Administrator submitted the revised Facility Assessment to the Quality Assurance Performance Improvement Committee for approval. On 6/11/21, the Regional Nurse Consultant conducted an educational session to review the revised Facility Assessment with the Department Heads. 2. All residents have the potential to be affected by the deficit practice cited. 3. In the QAPI meeting held 6/11/21, the facility assessment was discussed and determined that the facility assessment would be updated as appropriate when areas needing improvement are identified in future QAPI meetings. 4. QAPI meetings have been scheduled on the facility calendar every other week beginning 7/16/21 and monthly beginning 8/28/21 times two. A schedule was created to bring audit findings to QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 838}	Continued From page 255 The IJ and Substandard Quality of Care (SQC) existed at §483.70(e) §483.70(e)(1) §483.70(e)(2) Facility assessment.. The IJ was not removed prior to the State Agency (SA) exit on 5/26/2021 and was considered ongoing. The facility provided a Credible Removal Plan, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interviews and in-service sign-in sheets review. The facility provided evidence the facility had implemented corrective actions listed in the Credible Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for 42 CFR at §483.70(e) §483.70(e)(1) §483.70(e)(2) has been lowered from the scope and severity of a "L" to the scope and severity of an "F". The facility will remain out of compliance at Scope and Severity of "F" that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Review of the facility assessment dated April	{F 838}	meetings. Facility assessment has been added to the QAPI template for discussion in QAPI meetings. The facility assessment will be reviewed and revised January 2022. The Administrator or Administrator in training will ensure that QAPI meetings occur and minutes completed. Findings will be brought to QAPI monthly for review, revision, or resolution of the plan. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance. The Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 838}	Continued From page 256	{F 838}		

2021 revealed the facility failed to address the overall staffing needed, staff competencies needed and services necessary to provide care to residents in the facility.

On 5/20/21 at 09:15 AM, during an interview with the Director of Nursing (DON) stated she had never seen the facility assessment and does not understand what it does. The DON stated she depended on the Administrator to explain and make sure the facility was following the facility assessment.

On 5/20/21 at 10:00 AM, an interview with the Regional Director of Operations confirmed the facility assessment does not guide the facility on staffing and how to meet the needs of the residents. The administrator is responsible for having an appropriate facility assessment.

On 05/20/21 at 2:00 PM, an interview with the Administrator revealed he is responsible for the facility assessment. The Administrator confirmed the facility assessment is not sufficient to meet the needs of the residents in this building. The Administrator also confirmed the assessment does not give guidance on wound care/lifts or competent staff. The Administrator stated he needed to correct the assessment.

Removal Plan:
On 5/6/21, the Regional Director of Operations issued a written corrective action to the Administrator regarding the development of an effective Facility Assessment.
On 6/1/21, the Senior Director of Operations and other corporate staff assisted the Administrator in the revision of the Facility Assessment to:
Provide for an evaluation of the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 838}	Continued From page 257	{F 838}		

population.
o Identify the resources needed to provide the necessary competent staff; and
o Guide the facility on staffing and how to meet the needs of the residents to ensure the person-centered care and services that the residents require.
On 6/4/21, the Administrator submitted the revised Facility Assessment to the QAPI Committee for approval.
On 6/11/21, the Regional Nurse Consultant conducted an educational session to review the revised Facility Assessment with the Department Heads.
In the QAPI meeting held 6/11/21, the facility assessment was discussed and determined that the facility assessment would be updated as appropriate when areas needing improvement are identified in future QAPI meetings.
Validation:
The State Survey Agency (SSA) validated through record review and interviews the Regional Director of Operations issued a written corrective action to the Administrator, regarding the development of an effective Facility Assessment.
The SSA validated through review of the Facility Assessment, the facility had developed a Facility Assessment that evaluated the resident population, identified resources needed, and guided the facility to completely provide care to the residents who reside in the facility.
The SSA validated through interviews of Department Heads and record review of QAPI meeting minutes, the Facility Assessment was revised and presented to the Quality Assessment and Performance Improvement (QAPI) Committee for approval.
The SSA validated through interviews with Department Heads, the Regional Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 838}	Continued From page 258 Consultant reviewed the revised Facility Assessment with the Department Heads. The SSA validated through interviews with QAPI Committee members and review of QAPI meeting minutes, the revised Facility Assessment was discussed and determined that the Facility Assessment would be updated in the future when the needs for improvement were identified.	{F 838}		
{F 841} SS=F	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to have an effective Medical Director to act on reported deficient practices for resident care policies, for current professional standards of practice related to abuse/neglect, remain free from avoidable accidents, wound care, behavioral health care, missed significant medications, competent and sufficient staffing, complete and accurate documentation of the medical records and following and revising resident care plans and to oversee the facility's policies and Quality Assurance Performance Improvement (QAPI) program prior to the State Agency (SA) entering the facility on 5/4/21, for the Complaint Investigation survey. This had the potential to affect 65 of 65 residents in the facility.	{F 841}	1. On 5/6/21, and 5/21/21, the Medical Director (at the time of the survey) participated in the Quality Assurance Performance Improvement Committee meetings where the survey results and residents affected and potentially affected were discussed. The Governing Body and the Facility determined that a change in the Medical Director would benefit the residents and the Facility. On 5/25/21, the Owner/Managing Member met with a potential new Medical Director for the Facility and discussed all survey findings. On 5/26/21, the new Medical Director was contracted for the Facility. The Medical Director officially accepted the role and responsibilities of the Medical Director as	7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 841}	Continued From page 259 The failure of the facility to have a Medical Director to evaluate and act on reported deficient practices for resident care policies, for current professional standards of practice related to wound care, abuse/neglect, behavioral health care, missed significant medications, pharmacy services, have competent and sufficient staffing, have complete and accurate documentation of the medical records, reviewing polices and the Quality Assessment and Performance Improvement (QAPI) program concerns was likely to cause serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) on 5/24/21 and was determined to exist on 11/17/20. The SA identified the failure of the facility's Medical Director to act on reported deficient practices for resident care policies, for current professional standards of practice related to abuse/neglect, behavioral health care, missed significant medications, pharmacy services, have competent and sufficient staffing, have complete and accurate documentation of the medical records, reviewing polices and the Quality Assessment and Performance Improvement (QAPI) program concerns, had the likelihood of serious injury, harm, impairment, or death. The facility Administrator was notified of the IJ on 5/24/21 at 3:01 PM and was presented with the IJ template. The IJ existed at CFR. The IJ was not removed prior to the State Agency (SA) exit on 5/26/2021 and was considered ongoing.	{F 841}	of 5/26/21 and began fulfilling these responsibilities on 05/26/21. On 05/25/2021 the Administrator, Senior Director of Clinical Services, and Owner/Managing Member met with the new Medical Director to review the following: 1) the outcomes of the surveys; 2) expectations and roles of the Medical Director as outlined in the Rules and Regulations; 3) the Facility□s policies and procedures related to particular survey findings, including staffing/scheduling; the revised QAPI Committee Plan and QAPI Committee standardized agenda; reporting abuse, neglect, and exploitation; omission of medications; and reporting condition changes to family members. The Owner provided education on the responsibilities of the Medical Director and status of the Facility to the new Medical Director on 5/25/21. 2. All residents have the potential to be affected by the deficit practice cited. 3. Beginning 6/2/21 as a systemic approach, the new Medical Director reviews the following during the monthly QAPI Committee meeting: the audit material from the auditing schedule for adherence to the facility□s policies and procedures for staffing, incomplete documentation of medications, wound care reports, behavioral health services, and staff competencies for behavioral health needs. Beginning 6/03/21 the Administrator monitors the Medical Director□s effectiveness in reviewing and monitoring quality of care, i.e., falls, infections, pressure wounds, staffing, documentation issues and oral reports at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 841}	Continued From page 260 The facility provided a Credible Removal Plan, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interviews and in-service sign-in sheets review. The facility provided evidence the facility had implemented corrective actions listed in the Credible Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for CFR §483.70(h) §483.70(h)(2) Medical director has been lowered from the scope and severity of a "L" to the scope and severity of an "F". The facility will remain out of compliance at Scope and Severity of "F" that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: The facility's, "Medical Director" policy, dated 6/1/2020, noted, it is the policy of this facility that physician services are under the supervision of the Medical Director. This policy noted the Medical Director is a licensed physician in the state and is responsible for the standards, coordination, surveillance, and planning for improvement of medical care in the facility. This policy noted the Medical Director also acts as a liaison between administration and attending	{F 841}	the QAPI Committee meetings and reports to the Governing Body. Beginning 6/03/21 the Administrator ensures that the Medical Director is informed and reviewing any state reports of abuse, neglect, injury of unknown origin, unusual occurrences, misappropriation of property, unusual deaths, and standard of care issues such as excessive weight loss, medication documentation, acquired pressure wounds, staffing issues, competency, and other issues. 4. Beginning 7/1/21 Nursing home Administrator or Director of Nursing will log any concerns or issues regarding the new medical director as they occur. All will be reported to the regional director of operations. Findings will be brought to QAPI monthly beginning 7/2/21 for review, revision, or resolution of the plan. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance. The Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 841}	Continued From page 261	{F 841}		

physicians, acts as a consultant to the Director of Nursing services in relating to resident care services, assures the residents receives adequate services appropriate to meet their needs, assures the medical regimen is incorporated with the resident care plan, participates in staff meetings concerning, but not limited to infection control, quality assurance, pharmaceutical services, resident care policies. The Medical Director is also responsible for reviewing employee pre-employment and physical examination reports and is responsible for assuring physician services are in compliance with current rules, regulations, and guidelines concerning long-term care.

On 05/20/21 at 1:00 PM, in an interview with the Medical Director, he stated he is working on a month-to-month basis at this time. He confirmed he is part of the QAPI program and attends the monthly meetings. He confirmed he was aware the facility had concerns with staffing and medications not being available but stated he thought the concerns had been corrected. The Medical Director stated he had not reported any facility concerns to the State Agency (SA) or the Attorney General's (AG's) office. He confirmed he had talked to the corporate people (governing body and Regional Director of Operations) about the problems but stated the Administrator stated the facility has a contract with the local pharmacy to receive three (3) to seven (7) days of medications until the routine medication come in from the routine pharmacy. The Medical Director stated he was told by the Administrator the facility was going to bring in agency to cover for the shortage in staffing. The Medical Director stated he was not aware of residents being admitted with behaviors and abuse of other residents. He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 841}	Continued From page 262	{F 841}		

stated he did not know the Psychiatric Nurse Practitioner was not seeing the residents on the Alzheimer's/Dementia (A/D) unit. The Doctor confirmed he should have followed up on the deficient practice and he should have known about the deficient issues in the facility through QAPI.

On 05/20/21 at 12:30 AM, in an interview with local Medical Doctor (MD) stated the facility does not have enough staff to meet the needs of the residents. The MD stated she is the resident's Medical Doctor and works at the facility with the Nurse Practitioner (NP). The MD stated she has talked to the Administrator about her concerns at the facility. She stated she has concerns related to the residents not receiving medications in a timely manner and are always unavailable or on order. She stated the resident's go for days without medications. The MD stated she is not notified for several days that a resident did not receive their medications. She stated she also has concerns related to the facility does not complete appropriate wound assessments. The wound assessments are not done for several weeks at a time. The MD stated the Director of Nursing (DON) changes the wound care orders without permission because of the cost of the medication. The MD stated she has not been invited to the QAPI meetings because (proper name) is still the Medical Director. The MD stated she has met with the Administrator and DON about her concerns. The local MD also stated she reported several issues to the SA in December about low staffing and medication problems. The MD stated she has the NP to check the Medication Administration Records (MARS) to see if the residents are getting their medication because of the concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 841}	Continued From page 263	{F 841}		

Removal Plan:

On 5/6/21, 5/21/21, and 5/24/21, the Medical Director (at the time of the survey) participated in the QAPI Committee meetings where the survey results and residents affected and potentially affected were discussed.
The Governing Body and the Facility determined that a change in the Medical Director would benefit the residents and the Facility. On 5/25/21, the Owner/Managing Member met with a potential new Medical Director for the Facility and discussed all survey findings. On 5/26/21, the new Medical Director was contracted for the Facility. The Medical Director officially accepted the role and responsibilities of the Medical Director as of 5/26/21 and began fulfilling these responsibilities on 05/26/21.
On 05/25/2021 the Administrator, Senior Director of Clinical Services, and Owner/Managing Member met with the new Medical Director to review the following: 1) the outcomes of the surveys; 2) expectations and roles of the Medical Director as outlined in the Rules and Regulations; 3) the Facility's policies and procedures related to particular survey findings, including staffing/scheduling; the revised QAPI Committee Plan and QAPI Committee standardized agenda; reporting abuse, neglect, and exploitation; omission of medications; and reporting condition changes to family members.
The Owner provided education on the responsibilities of the Medical Director and status of the Facility to the new Medical Director on 5/25/21.
Validation:
The State Survey Agency (SSA) validated through interviews with QAPI members and QAPI sign-in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 841}	Continued From page 264 sheets, that the Medical Director employed at the time of the survey, participated in the QAPI Committee Meetings where the results of the survey and residents affected and potentially affected were discussed. The SSA validated through interview and record review, the Owner provided education on the responsibilities of the Medical Director and status of the facility regarding survey findings to the new Medical Director on 5/25/21. The SSA validated through interview and contract review, the new Medical Director signed a contract and officially accepted the role and responsibilities of the Medical Director on 5/26/21.	{F 841}		
{F 842} SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	{F 842}		7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 842}	Continued From page 265 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	{F 842}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 842}	Continued From page 266 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, and record review the facility failed to completely and accurately document in the clinical records for eight (8) of nine (9) residents reviewed for wounds. Residents #3, #5, #6, #7, #12, #13, #14, and #17. The Facility's failure to accurately document in the clinical records puts 8 of 9 residents at risk for the likelihood of serious harm, serious injury, serious impairment or death. This situation was determined to be an Immediate Jeopardy (IJ) on 05/21/2021 and was determined to exist on 04/06/2021 when the facility failed to assess wounds accurately and document findings in medical records. The IJ was not removed prior to exit on 05/26/2021 and is considered ongoing. The IJ existed at §483.70(i) Medical records. Findings Include: Resident #3 Record review for Resident #3's Admission Record revealed the facility initially admitted Resident #3 on 02/24/2019 with the diagnoses of Atrial Fibrillation, Type 2 Diabetes Mellitus, Pressure Ulcer Sacral Region Stage 3, Hemiplegia and Hemiparesis, Peripheral Vascular	{F 842}	1. On 5/23/2021, the Director of Nursing was educated by the wound care-certified Regional Nurse Consultant (RNC) regarding the skin and wound care process, including documentation of wounds. On 5/24/21, Corporate Management approved Wound Care Specialists from other facilities to work in the Facility to assist with Medical Record documentation. On 5/28/2021, the Certified Wound Care Nurse and Minimal Data Set Coordinator assessed wounds for staging and treatment for Residents #3, #6, #7, #13, #14, and #17 to ensure correct treatments were implemented and that interventions were appropriate for the wounds identified. Any necessary changes identified in treatment and medications were reported to the Nurse Practitioner. Any new physician orders were entered, care plans were reviewed for needed revisions and revised according as orders were approved. Resident #5 discharged on 01/21/21. Resident #12 discharged on 5/17/21. Beginning 5/28/21, the Assistant Director of Nursing/Infection Control Coordinator or Minimum Data Set Coordinator daily check nursing documentation entered into the Medical Record to ensure that no care is missed, and all care is documented. 2. All residents with skin integrity	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 842}	Continued From page 267 Disease, Cardiomegaly, and High Blood Pressure. Record review Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) dated for 2/15/21, Section M revealed Resident #3 had a Stage 3 pressure ulcer. Record review of Resident #3's Treatment Administration Record (TAR) for January 2021 revealed omitted documentation for the treatment of Stage 3 ulceration to sacrum on 1/1/21, 1/2/21, 1/8/21, 1/9/21, 1/10/21, 1/15/21, and 1/16/21 for a total of seven (7) entries omitted in January. Record review of the TAR for March 2021 revealed omitted documentation for the treatment of sacral wound on 3/9/21, 3/11/21, 3/15/21, 3/22/21, 3/27/21, and 3/28/21 for a total of six (6) entries omitted in March. Review of April 2021 TAR revealed omitted documentation for the treatment of sacral wound on 4/2/21, 4/3/21, and 4/7/21 for a total of three (3) entries omitted in April. Record review of the Weekly Pressure Injury Record for Resident #3 revealed one record dated 1/11/2021 which was incomplete. There are no other records indicating evaluation or assessment of wounds for January 1, 2021 through May 8, 2021. Resident #5 Record review of Resident #5's Admission Record revealed the facility admitted Resident #5 on 05/19/2020 with the diagnoses including but not limited to Pressure Ulcer of right buttock Stage 2, and Pressure ulcer of left heel,	{F 842}	concerns have the potential to be affected by the deficit practice cited. 3. Beginning 5/28/21 and continuing, the ADON/ICC, Certified Wound Care Nurse and RNC educated all nursing staff (Registered Nurses, Licensed Practical Nurses, Certified Nurse Aides) on the requirements of documentation of the following: wound measurements, Braden scale, notification of families about wounds and/or status of wounds, treatments provided, and written physician orders. The in-services were either in-person, in a classroom setting, or 1:1, either in person or by telephone. Any staff member not attending the initial in-service will be educated upon return and will not be permitted to work unless education is completed. Any staff member who fails to comply with the direction included in the in-services will be further educated and/or progressively disciplined. On 6/1/21 and 6/2/21, the Certified Wound Care Nurse, MDS Coordinator, and ADON/ICC conducted an audit of all other resident□s charts for missed documentation, such as any skin assessments or any treatments not documented. All residents□ comprehensive care plans were also checked for potential skin issues and were updated based on findings from the assessments. Beginning 6/03/21, an additional Certified Wound Care Nurse began auditing all residents for a new complete skin assessment. Any additional areas noted were communicated to the provider for new or revised orders. 4. The Director of Nursing or Assistant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 842}	Continued From page 268 unstageable, which indicated the pressure ulcers to right buttock and left heel were present on admission. Resident #5 was discharged to another facility on 1/21/2021. Record review of Resident #5's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of November 16, 2020, Section M of the MDS revealed Resident #5 had one (1) Stage 2 and one (1) unstageable wound. The latest Discharge MDS with ARD of 1/21/2021 revealed the same findings as the quarterly MDS. Record review of Resident #5's Initial Weekly Wound Pressure report dated 05/20/2020, revealed Resident #5 was admitted with a wound on the left heel, inner aspect, unstageable, with measurements of 2 cm x 1.4 cm x 0.2 cm and wound to right buttock Stage two with measurements 1 cm x 1 cm x 0.2 cm. Review of Resident #5's Nurse Progress Notes dated 05/25/2020 revealed a new area to left gluteal fold with partial thickness measurements of 1.5 cm x 0.5 cm x0.1 cm with cleansed area with wound cleanser pat dry, zinc oxide applied to area. There was no weekly body audit with the new wound to left gluteal fold with measurements. Review of Resident #5's weekly body audit dated 06/17/2020 revealed no measurements and continue treatment to coccyx and right foot. Further record review of Resident #5's weekly body audits dated 09/02/20, 09/28/20, 10/14/20 revealed body audits with wounds right and left buttock with no measurements recorded. A record review of Resident #5's TAR revealed an order for Santyl Ointment 250 unit/ gram (GM) TAR had missing documentation for 5/21/20 thru	{F 842}	Director of Nursing will review the wound care log weekly times four weeks beginning the week of 7/1/21 and then monthly times three months beginning 8/1/21. Residents identified with wounds will be discussed during the weekly Persons At Risk meeting beginning the week of 7/1/21. Findings will be brought to Quality Assurance Performance Improvement monthly beginning 7/2/21 for review, revision, or resolution of the plan. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance. The Administrator will report to the Governing Body and Management Company the monitoring outcomes monthly beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 842}	Continued From page 269 5/23/20 ,5/27/20 thru 5/29/20. A record review of the TAR for Stage 2 Right Buttock wound care on 5/21/20 , 5/22/20, 5/27/20, 5/28/20 and 5/29/20 revealed no nurse initials for those dates. The unstageable ulceration to left heel inner aspect wound care for Hydrogel had missing documentation for 5/28/20 thru 5/29/20. Resident #6 Record review of Resident #6's Physician Order dated 1/21/21 revealed an order to changed Duoderm dressings to bilateral ankles every three (3) days. Record review reveals that there are no records indicating consistent assessment or measurement of ankle wounds from January 28 through May 8, 2021. A Pressure Report dated 05/08/2021 revealed Resident # 6 with pressure wounds to bilateral ankles with measurements left ankle 1.5 cm x 1.2 cm and right ankle 1.5 cm x 1.5 cm with Stage 2 noted with eschar tissue per DON skin assessment. Record review of Resident #6's weekly body audit dated for 01/08/2021 only reports no new skin alterations. Body audits dated 03/02/2021, 04/27/2021, 05/06/2021 revealed no measurements of wound to ankles and no weekly pressure injury records available. A weekly body audit dated 03/03/2021 revealed right and left ankles with both wounds measuring 1.0 cm x 1.0 cm with callous like wound on ankles. Three weekly skin reports provided by the DON revealed on 01/28/2021 Resident #5 had bilateral ankle abrasions with one measurement of 2.0 cm	{F 842}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 842}	Continued From page 270	{F 842}		

x 2.0 cm; on 03/15/2021 resident had non-pressure wounds to bilateral ankles, the wounds were facility acquired and a measurement of 2.0 cm x 2.0 cm one set of measurements for bilateral ankles; and on 04/13/2021 facility acquired non-pressure wounds to bilateral outer ankles and a measurement of 1.5 cm x 1.5 cm.

Record review of Resident #6's Admission Record revealed the facility initially admitted Resident #6 on 07/31/2017 and readmitted on 01/16/2019 with the diagnoses of Cerebral Infarction, Atrial Fibrillation, High Blood Pressure, and anxiety disorder. The Admission Record revealed Resident #6 had an added diagnosis of Pressure ulcer Stage 2 to unspecified ankle on 05/07/2021.

Record review of Resident #6's Annual MDS with ARD date 2/26/2021 Section M revealed Resident #6 had a Pressure ulcer of 1 or greater or a scar over a bony prominence. Section M had no other areas flagged for skin conditions. Resident #6's Quarterly MDS with ARD date 12/08/2020 Section M had no areas flagged for skin conditions.

Resident #7

Record review of the Physician Order dated 07/07/20 and discontinued on 04/06/20 revealed Stage 3 to sacral/gluteal cleft cleanse with wound cleanser and pat dry apply puracol to wound bed, cover with Opti foam dressing daily. Review of a Physician Order dated 04/14/21 revealed cleanse sacral and hip wound with wound cleanser, pat dry, apply Aquacel Alginate foam pad apply to sacral and hip wound topically one time a day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 842}	Continued From page 271	{F 842}		

Record review of Resident #7's Weekly Pressure Injury Records revealed one record dated 5/8/2021. There are no other records indicating evaluation or assessment of wounds for January 1, 2021, through May 8, 2021.

Record review of Resident #7's Admission Record revealed the Facility initially admitted on 9/4/2018 and readmitted on 4/13/2021 with the following Medical Diagnoses include Type 2 Diabetes Mellitus, Heart Failure, Cardiomegaly, Cerebral Infarction, and Essential Hypertension. The Admission Record also revealed Resident #7 was diagnosed with Pseudomonas and Urinary Tract Infection 04/14/2021 and Sepsis on 04/13/2021.

Record review of the Discharge Minimum Data Set (MDS) dated April 18, 2021, Section M of the MDS revealed Resident #7 had only one Stage 3 wound.

Resident #12

Record review of Resident #12's Physician Orders revealed orders for A and D ointment to buttock topically two times a day with Nystatin and triamcinolone with start date 04/14/2021, hydrogel apply to Stage 2 buttock topically two times a day for decubitus buttock with a start date 12/31/2021, and a new order on 05/10/2021 for zinc oxide apply to buttocks. Resident also had order to send to the local wound care clinic every 2 weeks with start date 03/16/2021. An order with start date 01/01/2021 noted clean bilateral knees with normal saline, pat dry apply Promogran to wound beds, secure with border gauze and changer every 48 hours, and another order with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 842}	Continued From page 272	{F 842}		

start date 04/20/2021 cleanse wound to left and right anterior knee with normal saline, pat dry, apply Silvadene to wound bed and cover with a border dressing one time a day for wound care.

Record review of Resident's #12's TAR for April 2021 revealed omitted documentation for the treatment of bilateral lower extremities on 4/3/21 and 4/11/21 and omitted documentation for area to buttocks on 4/4/21, 4/7/21, 4/11/21, 4/20/21, 4/22/21, 4/23/21, 4/24/21, 4/28/21 and 4/29/21 for a total of eleven (11) entries omitted in April. Record review of the May TAR revealed omitted documentation for the treatment of buttocks on 5/2/21, 5/7/21, 5/8/21, and 5/9/21 for a total of four (4) entries omitted in May.

Record review of the Weekly Pressure Injury Record for Resident #12 revealed one record dated 4/19/2021 for area to right buttock.

There are no other records indicating evaluation or assessment of wounds for January 1, 2021, through May 8, 2021.

Record review of Admission Record revealed the facility initially admitted Resident #12 on 10/24/2021 and readmitted on 1/6/2021 with Medical Diagnoses of Unspecified Atrial Fibrillation, Peripheral Vascular Disease, Chronic Embolism, Morbid obesity, Pressure ulcer of right buttock Stage 2, Non-pressure chronic ulcers skin, Thrombosis of Unspecified Deep Veins of Unspecified Lower Extremity, Chronic Kidney Disease, and Essential Hypertension.

Record review of the Quarterly Minimum Data Set (MDS) dated April 16, 2021, Section M of the MDS revealed Resident #12 had one Stage 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 842}	Continued From page 273	{F 842}		

ulcer.

Resident #13

Record review of Resident #13's Physician Orders revealed order for heel protectors bilaterally due to skin breakdown on left heel start date 12/31/2020, betadine solution apply to left heel topically one time a day for 14 days started on 01/01/2021 and then restarted on 01/22/2021 for 10 days and then again on 02/02/2021. A new order for Santyl Ointment apply to left heel and cover with gauze dressing one time a day for wound care start on 03/03/2021. Another order to inspect resident feet daily started on 04/14/2021.

Record review of Resident #13's medical records revealed the facility had no weekly pressure injury records for Resident #13 and there are no other records indicating evaluation of wounds from 01/01/2021 through 05/08/2021.

Record review for Resident #13's Admission Record revealed the facility admitted Resident #13 initially on 04/04/2018 and readmitted on 11/30/2020 with diagnoses of Type 2 Diabetes Mellitus, High Blood Pressure, and Convulsions. The Admission Record revealed Resident #13 was diagnosed with Pressure ulcer of left heel Stage 2 on 04/16/2021.

Record review of Resident #13's Quarterly MDS with ARD date 04/28/2021, Section M revealed Resident #13 had one Stage 2 pressure ulcer.

Resident #14

Record review of Resident #14's Physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 842}	Continued From page 274	{F 842}		

Orders printed 05/10/2021 revealed orders for ensure hydrocolloid dressings are applied to left and right great toes and coccyx ulcers as ordered change dressings every 3 days and when visibility soiled as ordered date, initial, and time every dressing and document every dressing change in progress notes. The order was started on 01/10/2021 and discontinued on 03/15/2021 related to coccyx wound healed. An order was started on 03/16/2021 for ensure hydrocolloid dressings are applied to left and right great toes as ordered, change dressings every 3 days and when visibility soiled as ordered date, initial, and time every dressing and document every dressing change in progress notes, and inspect resident's feet daily every shift, an order was started on 12/13/2021 for Hydrocol pad apply to left and right 1st toes ulcers topically every 72 hours, change dressings every 3 days and when visibility soiled and order discontinued on 04/09/2021 resolved.

Record review revealed that there are no records indicating assessment or measurement of wounds from January 1 through May 8, 2021. The Treatment Administration Record (TAR) Lacks documentation of application of Hydrogel and covering of Hydrocol Pad to left and right first toe ulcers on 3/13/21, 3/22/21 and 4/3/21.

Record review of Resident #14's Admission Record revealed the facility initially admitted Resident #14 on 05/20/2015 and readmitted on 08/14/2018 with the diagnoses of Hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side, Depressive disorder, Slurred speech, and Alzheimer's Disease. The Admission Record also revealed Resident #14 was diagnosed with Stage 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 842}	Continued From page 275	{F 842}		

pressure ulcer unspecified buttock 01/29/2021.

Record review of Resident #14's Quarterly MDS with ARD date of March 1, 2021, Section M of the MDS revealed Resident #14 had no pressure, venous, or arterial ulcers, but did have moisture associated skin damage.

Resident #17

Record review of Resident #17's Physician Orders from 03/01/2021 thru 05/31/2021 revealed an order dated 05/13/2021 cleanse sacral decubitus with ¼ strength Dakin's Solution, apply gentamicin sulfate powder to wound bed, pack wound with silver alginate, cut sponge to fit within wound bed, place wound vac at 125 pressure continuous suction change on Tuesday and Friday or sooner if there is suction malfunction, in case of wound vac malfunction, cleanse sacral decubitus with ¼ strength Dakin's solution, apply gentamicin sulfate powder to wound bed, pack wound with silver alginate and cover with bandage and notify provider. Stage 2 ulceration at site of urinary catheter insertion wound caused from pressure from the catheter, cleanse area with soap and water, dry, apply mixture of A and D ointment, Nystatin ointment, and triamcinolone cream daily, and wound care follow up at Field on 05/20/2021. Resident #17 had an order for body audit weekly and as needed. The Physician Orders revealed since Resident #17 had been admitted to the facility he has received oral, intramuscular, and intravenous antibiotics for wound infection, osteomyelitis, and gram-negative sepsis including Ceftriaxone 1 gram (gm) one time a day, Cipro tablet 500 milligram (mg) every 24 hours, clindamycin 300 mg, Levofloxacin 750mg/150 ml every 24 hours,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 842}	Continued From page 276	{F 842}		

Levofloxacin tablet 750 mg one time a day, and Meropenem 1 gm every eight hours.

Record review revealed missing documentation of wound care on the TAR for Hydrocel Gel to sacral wound on 03/28/2021, 04/03/2021, 04/11/2021; Providone-Iodine Solution to wounds to toes on 04/10/2021, 04/22/2021; Dakin's ¼ strength and hydrogel to sacral wound on 4/03/2021, 04/10/2021, 04/11/2021, 04/24/2021, and 04/29/2021.

Record review of weekly pressure injury records for Resident #17 revealed only four (4) weekly pressure reports for sacral wound dated 03/04/2021, 03/15/2021, 04/07/21, and 05/08/2021 in Resident #17's medical records. There were no other weekly pressure injury records provided by the facility.

Record review of Resident #17's Admission Record revealed the facility originally admitted Resident #17 on 3/4/2021 and readmitted on 3/10/2021 with the Medical Diagnoses of Osteomyelitis of Vertebra, Sacral and Sacrococcygeal Region, Unstageable Pressure Ulcer of Sacral Region, Congestive Heart Failure, Diabetes Mellitus due to Underlying Condition with Foot Ulcer, Chronic Obstructive Pulmonary Disease, Chronic Peripheral Venous Insufficiency and Essential Hypertension.

Record review of Resident #17's 5-day Minimum Data Set (MDS) with ARD of March 12, 2021, revealed Section M of the MDS revealed Resident #17 had one unstageable wound due to non-removable dressing/device and one unstageable wound due to slough or eschar, diabetic foot ulcer and other open lesions on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 842}	Continued From page 277 foot. On 5/5/2021 at 3:00 PM, in an interview with the DON, when asked if a treatment is not initialed what does that mean, she reported if it is not documented than it is not done. She further explained the treatments on the Treatment Administration Record should be initialed after the treatment is done. On 05/06/21 at 10:50 am interview with the DON, she explained she just started doing weekly wound care reports. She explained that she has not been consistent with doing wound reports. She explained the nurses on the med carts do the treatments and the measurements for each wound. 5-6-21 at 5:30 PM in an interview with the Nurse Consultant, she explained the DON has not been consistent with wound care reports for months.	{F 842}		
{F 865} SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.	{F 865}		7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 865}	Continued From page 278 §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide documented evidence that it has, through its Quality Assurance and Performance Improvement (QAPI) Program, reviewed and analyzed data for concerns related to Abuse/Neglect, Reporting Abuse and Neglect, Developing a Baseline Care Plan, failure to implement and follow the resident's Care Plan, failure to revise the resident's Care Plan, Monitor treatments and care for Pressure Ulcers, remain free from avoidable accidents, have sufficient Nursing Staff, have competent Nursing Staff, provide Behavioral Health Services, have sufficient/competent staff for Behavior Health Needs, monitor Pharmacy Services, failed to monitor for Significant Medication Errors, failed to monitor facility Administration, failed to monitor the Governing Body for effectiveness, failed to develop a Facility Assessment, failed to monitor for accurate and complete resident records, and failed to call meetings to review and analyze data regarding these concerns prior to the State Agency (SA) entering the facility on 5/4/21, for the Complaint Investigation survey. This had the potential to affect 65 of 65 residents in the facility. The failure of the facility to utilize the QAPI program to determine the root cause of Abuse/Neglect, failure to report Abuse and Neglect, failure to develop a Baseline Care Plan, failure to implement and follow the resident's Care Plan, failure to revise the resident's Care	{F 865}	1. Quality Assurance Performance Improvement Committee Meetings were held on 5/6/21, 5/8/21, and 5/21/21 to discuss abatement and develop interventions to remove the immediate jeopardies related to F600, F609, F656, F657, F686, F725, F726, 740, F741, 755, F760, F835, 837, F838, F841, F842 and F865. The QAPI Committee meeting attendees included the Administrator, the Director of Nursing Services (DON), Medical Director, Infection Control Coordinator/Assistant Director of Nursing (ADON), Dietary Manager (DM), Maintenance Supervisor, Admissions Coordinator, Human Resource/Business Office Manager (BOM), MDS Coordinator, Rehabilitation Director, Lead Certified Nursing Assistant, Housekeeping Supervisor, and Life Connections Assistant. The DON & Administrator, with the assistance of an Independent Consultant, reviewed and revised the QAPI Committee Plan, presented the Plan at the QAPI Committee meeting on 5/21/21, and discussed a standardized agenda and minute format to ensure all topics and reports are reviewed and addressed monthly. During the QAPI Committee Meetings, the Senior Director of Clinical Services and Owner/Managing Member educated the QAPI Committee on the QAPI Committee process and the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 865}	Continued From page 279 Plan, monitor treatments and care for Pressure Ulcers, remain free from avoidable accidents, have sufficient Nursing Staff, have competent Nursing Staff, provide Behavioral Health Services, have sufficient/competent staff for Behavior Health needs, monitor Pharmacy Services, failed to monitor for Significant Medication Errors, failed to monitor facility Administration, failed to monitor the Governing Body for effectiveness, failed to develop a Facility Assessment, failed to monitor for accurate and complete resident records and identify deficient practices was likely to cause serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) on 5/21/21 and began on 11/17/20, when the SA entered the facility and identified the failure of the facility's QAPI Committee to meet, review, and analyze data to develop corrective actions to prevent Abuse/Neglect, prevent failure to report Abuse and Neglect, prevent the failure to develop a Baseline Care Plan, prevent the failure to implement and follow the resident's Care Plan, prevent the failure to revise the resident's Care Plan, failed to monitor treatments and care for Pressure Ulcers, prevent injury to prevent avoidable accidents, have sufficient Nursing Staff, have competent Nursing Staff, provide Behavioral Health Services, have sufficient/competent staff for Behavior Health Needs, monitor Pharmacy Services, failed to monitor for Significant Medication Errors, failed to monitor facility Administration, failed to monitor the Governing Body for effectiveness, failed to develop a Facility Assessment, failed to monitor for accurate and complete resident records to decrease the likelihood of serious injury, harm, impairment, or death. The facility Administrator was notified of	{F 865}	revised agenda. The Senior Director of Clinical Services and Owner/Management Member also introduced the necessary audits with corresponding calendars and revised trending tools. QAPI Committee members included the Administrator, DON, Medical Director, ADON/ICC, Dietary Manager, BOM/HR, Life Connections, Housekeeping Supervisor, Admissions Coordinator, MDS Coordinator, Rehabilitation Director, Lead Certified Nursing Assistant, Maintenance Supervisor, and Medical Records. The Owner/Managing Member and Senior Director of Clinical Services, as members of the Governing Body, provided education to the QAPI Committee on regarding the need to participate regularly in the QAPI Committee process and the need to identify Root Causes. Upon notification of the Immediate Jeopardies on 5/26/21, the Governing Body engaged an Independent Consultant to assist with the development of a functioning QAPI Committee. On 5/28/21, the Owner of the Company hired a consulting agency to provide additional training as well as auditing, monitoring, and guidance for the facility management. 2. All residents have the potential to be affected by the deficit practice cited. 3. Beginning 6/01/21, the Administrator conducts QAPI Committee meetings regularly, with a planned agenda and recorded minutes for each meeting. On 6/01/21 the Senior Director of Clinical Services invited the QIO agency staff to provide consultation on adverse events, and to assist with determining root	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 865}	Continued From page 280 the IJ on 5/21/21 at 3:30 PM and was presented with the IJ template. The IJ existed at CFR(S): §483.75(a) §483.75(a)(1 §483.75(a)(4) §483.75(b) §483.75(b)(1) §483.75(b)(2)) §483.75(b)(3) §483.75(b (4) §483.75(f) §483.75(f)(1) §483.75(f)(2) §483.75(f)(3) §483.75(f)(4) §483.75(f)(5) §483.75(f)(6) Quality assurance and performance improvement (QAPI) program. The IJ was not removed prior to the State Agency (SA) exit on 5/26/2021 and was considered ongoing. The facility provided a Credible Removal Plan, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interviews and in-service sign-in sheets review. The facility provided evidence the facility had implemented corrective actions listed in the Credible Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for 42 CFR 483.45(f)(2) has been lowered from the scope and severity of a "K" to the scope and severity of an "E". The facility will remain out of compliance at Scope and Severity of "E" that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness	{F 865}	causes, systemic failures, and/or developing corrective actions. The QIO agency advised the Governing Body on 6/07/21 that they do not provide on-sight services but can provide training materials for staff education for the areas of deficiencies that the facility received. Beginning 6/01/21 the Administrator, with the oversight of the Governing Body, has held weekly QAPI Committee meetings and will do so through the week of July 5th. QAPI will then be held every other week for 4 weeks, then monthly thereafter. Beginning 6/07/21, the Administrator will provide all QAPI Committee meeting minutes (in their new format) to the Governing Body (Owner and/or Director of Operations) for review of all audit results that are completed per the QAPI Committee calendar. Beginning 6/08/21 all monitoring of each deficiency is reported to the QAPI Committee as its regular meetings and to the Owner/Governing Body. A delegate of the Governing Body was onsite to attend the QAPI meetings. 4. QAPI meetings have been scheduled on the facility calendar every other week beginning 7/16/21 then monthly times two months beginning 9/3/21. A schedule was created to bring audit findings to QAPI meetings. Facility assessment has been added to the QAPI template for discussion in QAPI meetings. The facility assessment will be reviewed and revised January 2022 and as changes within the facility warrant an updated assessment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 865}	Continued From page 281 of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: The facility's, "Quality Assessment and Performance Improvement" policy, undated, noted the facility will implement and maintain a Quality Assessment and Performance Improvement program. This policy overview noted, "The QAPI committee will implement a process that is ongoing, multi-level, and facility wide that encompasses managerial, administrative, clinical, ancillary, and environmental services as well as contracted services and suppliers. The program should address all systems of care and management practices while emphasizing safety, quality of life, and resident choice." This policy noted, the primary purpose of the committee is to identify and analyze actual or potential quality issues, develop, and implement appropriate plans to improve performance, to address identified quality issues, and monitor the effectiveness of implemented changes. The committee will make any needed revisions to performance improvement plans. Other purposes of the QAPI committee are to maintain satisfactory, consistent functioning of systems, to prevent deviations from care process (to the extent possible), to discern issues and concerns with facility systems, and to correct said systems as needed. The committee will ensure that information about the QAPI committee activity is provided to consultants and other who are not members of the committee but have responsibility of the Governing Body oversight. The QAPI committee will be responsible for reviewing the Quality Assessment and Performance Improvement plan at least	{F 865}	The administrator or administrator in training will ensure that QAPI meetings occur and minutes completed. Findings will be brought to QAPI monthly for review, revision, or resolution of the plan. Independent monitoring by an outside consulting firm is being performed for compliance assistance. The Administrator will report to the Governing Body and Management Company the monitoring outcomes monthly beginning 7/1/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 865}	Continued From page 282	{F 865}		

annually for necessary revisions or changes. Records of annual reviews or amendments will become a part of the QAPI committee's permanent records.

On 5/17/21 at 12:00 PM, in an interview with the Administrator (ADM) and the Director of Nursing (DON) revealed the facility has QAPI meetings monthly. The Administrator stated the facility discusses high risk issues and other problems that arise in the other departments. The Administrator stated he conducts the QAPI meetings, and each department head discusses issues in their departments. The QAPI interdisciplinary team monitors these issues to ensure the corrective action has been implemented and the correction is being sustained. The Administrator and the DON stated the facility discussed wounds in the April 2021 (4/22/21) meeting. The meeting revealed the DON needed wound care training. The recommendation of the QAPI team was for the DON to follow the Medical Nurse Practitioner (MNP) for training and to send the residents with large wounds to wound care. The DON is responsible for assessing and measuring the wounds weekly. The DON will do the weekly wound reports and notify the doctor and the Responsible Party (RP) of the residents wound status. The DON said she never got the chance to receive the training from the MNP. The DON said she has not had any training since nursing school. She has done some wound care, but it was with hospice for palliative care. She has not done curative care. The ADM said the QAPI facility was asked, how does the QAPI committee know when an issue arises in any department? The Administrator stated the Committee meets monthly with all department heads and all high

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 865}	Continued From page 283	{F 865}		

risk and problematic concerns are discussed.
The SA asked, how does the QAPI committee know when a deviation from performance or a negative trend is occurring? Administrator revealed the department heads discuss whether the things put in place is working are not. The team meets every morning. The SA asked, is there a mechanism for staff to report quality concerns to the QAPI committee? The Administrator and DON stated they have an open-door policy. The SA asked, how does the QAPI committee decide which issues to work on? The Administrator stated they discuss all high-risk issues with the team every morning to decide what is more urgent. The SA asked how does the QAPI committee know that corrective action has been implemented? They stated the department heads follow up and reports daily in stand up. The SA asked, how does the QAPI committee know when improvement is occurring? They stated through the department heads daily at stand up. The SA asked, how long will the QAPI committee monitors an issue that it has corrected? The Administrator stated they will track and trend for a couple of months and make a decision whether to continue or change to something else. The SA asked, how is this decided? He answered, through the interdisciplinary team.
In an interview on 5/1//21 at 12:30 PM with the Assistant Director of Nursing (ADON) confirmed the facility meets monthly for a QAPI meeting. The ADON said the facility discussed high risk issues from all departments. The QAPI committee discusses ways to resolve the problems and put things in place. The committee follows up in the stand up and at the monthly meetings.

On 5/20/21 at 09:15 AM, in a interview with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 865}	Continued From page 284	{F 865}		

DON, she stated the QAPI meeting is conducted monthly. The team reviews high risk issues. The DON stated at the last meeting, the team discussed wound care. The QAPI committee determined the DON will continue to assess and monitor wound care and the DON would complete the weekly wound assessments and measurements. The team also discussed residents with behaviors and the team did not have any recommendations. Social Services brings grievances to the QAPI meeting. The DON stated they discussed weight loss, Urinary Tract Infections, and residents with behaviors.

On 5/20/21 at 10:00 AM, in an interview with the Regional Director of Operations (RDO) stated the facility uses a software company to audit the facilities weekly cooperate audio calls and does questionnaires. This information is pulled from the Minimum Data Set (MDS) system. This system helps to tell the problems the facility is having. The RDO stated the QAPI is done from the Administration level. The QAPI team discusses incidents reports and reportable events. The RDO confirmed she expected the QAPI program to discuss all programs. The RDO confirmed the QAPI program is ineffective. The RDO stated the staff needs more education on medications, handling behaviors, and providing wound care. The RDO confirmed the facility assessment does not guide the facility on staffing and how to meet the needs of the residents. The RDO stated the Administrator is responsible for having an appropriate facility assessment. The RDO confirmed the facility was aware of the problem with getting the resident's medications. The RDO stated the facility has a back-up pharmacy. The RDO stated the nursing consultant reported several times the DON is not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 865}	Continued From page 285	{F 865}		

efficient and competent in her role. The RDO stated the deficient practice started from the COVID-19 pandemic with the prior DON because the facility did not have enough staff. The RDO and the Clinical Nurse Consultant identified the medication problem in October. The RDO stated they were unaware if it was discussed in the QAPI meeting. The RDO confirmed the staff is not competent to take care of residents with psychiatric behaviors.

On 05/20/21 at 1:00 PM, in an interview with the Medical Director, he stated at this time he is on a month-to-month contract with the facility. The doctor revealed he is part of the QAPI team and attends the monthly meetings. The doctor stated he was aware of the concerns with low staffing and medications not being available. The doctor stated he did not report this to the State Agency (SA) or the Attorney Generals (AG's) Office. The Medical Director stated he thought the facility had corrected the problems and he talked to the corporate people about the problems. The Medical Director stated he was told by the Administrator the facility has a contract with the local pharmacy to receive three (3) to seven (7) days of medication until the routine medication comes in. The Medical Director stated the Administrator told him the facility was going to bring in Agency staff to help cover the low staffing and said he was not aware of the residents that were admitted with behaviors. He also stated he was not aware the Psychiatric Nurse Practitioner (NP) was not seeing the residents on the Alzheimer's Dementia (A/D) Unit. The Medical Director confirmed he should have followed up on the deficient practice and he should have known about the deficient issues in the facility through the QAPI program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

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LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 865}	Continued From page 286 A record review of the facility's QAPI committee meeting, dated 1/19/21, revealed that the meeting was held with no information the topic of the meeting. All required disciplines were present, either in person or by phone. A record review of the facility's QAPI committee meeting, dated 3/18/21, revealed that the meeting was held with no information the topic of the meeting. No signature for the required Medical Director was noted on the sign in sheet and no documentation of him being notified by phone. A record review of the facility's most recent QAPI committee meeting, dated 4/22/21, revealed that the meeting was held with no information the topic of the meeting listed and only a signature sheet was provided. All required disciplines were present. Removal Plan: QAPI Committee Meetings were held on 5/6/21, 5/8/21, 5/21/21, and 5/24/21 to discuss abatement and develop interventions to remove the immediate jeopardies related to F600, F609, F656, F657, F686, F725, 726, 740, 741, 755, 760, 835, 837, 838, 841, 842 and 865. The QAPI Committee meeting attendees included the Administrator, the Director of Nursing Services (DON), Medical Director, Infection Control Coordinator/Assistant Director of Nursing (ADON), Dietary Manager (DM), Maintenance Supervisor, Admissions Coordinator, Human Resource/Business Office Manager (BOM), MDS Coordinator, Rehabilitation Director, Lead Certified Nursing Assistant, Housekeeping Supervisor, and Life Connections Assistant. The DON & Administrator, with the assistance of	{F 865}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{F 865}	Continued From page 287	{F 865}		

an Independent Consultant, reviewed and revised the QAPI Committee Plan, presented the Plan at the QAPI Committee meeting on 5/21/21, and discussed a standardized agenda and minute format to ensure alt topics and reports are reviewed and addressed monthly.
On 5/24/2021 during the QAPI Committee Meetings, the Senior Director of Clinical Services and Owner/Managing Member educated the QAPI Committee on the QAPI Committee process and the revised agenda. The Senior Director of Clinical Services and Owner/Management Member also introduced the necessary audits with corresponding calendars and revised trending tools. QAPI Committee members included the Administrator, DON, Medical Director, ADON/ICC, Dietary Manager, BOM/HR, Life Connections, Housekeeping Supervisor, Admissions Coordinator, MDS Coordinator, Rehabilitation Director, Lead Certified Nursing Assistant, Maintenance Supervisor, and Medical Records.
The Owner/Managing Member and Senior Director of Clinical Services, as members of the Governing Body, provided education to the QAPI Committee on 5/24/21 regarding the need to participate regularly in the QAPI Committee process and the need to identify Root Causes.
Upon notification of the Immediate Jeopardies on 5/26/21, the Governing Body engaged an Independent Consultant to assist with the development of a functioning QAPI Committee.
On 5/28/21, the Owner of the Company hired a consulting agency to provide additional training as well as auditing, monitoring, and guidance for the facility management.
Corrective actions implemented by the facility were validated as follows:
The State Survey Agency (SSA) validated through

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{F 865}	Continued From page 288 interviews and record review the QAPI Committee Plan had been revised and reviewed by the QAPI Committee. The SSA validated through QAPI sign in sheets and interviews with QAPI Committee Members meetings were held to discuss abatement and develop interventions to remove the immediate jeopardies. The SSA validated through interviews with QAPI Committee members, the Owner/Managing Member and the Senior Director of Clinical Services educated the QAPI Committee on the QAPI Committee process and the importance of regular participation and the need to identify Root Causes. The SSA validated through interviews with contracted independent consultant and record review of contract of consulting agency, the Governing Body engaged an Independent Consultant to assist with the development of a functioning QAPI Committee, to provide additional training, auditing, monitoring, and guidance for the facility management.	{F 865}		