MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 000	Initial Comments MS Complaint #17430, #17473, #17381, #17774 An abbreviated/partial extended survey of MS Complaint #17430, 17473, 17381, 17774 and were initiated 05/04/21 and concluded 05/26/21. During the survey, the facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. A. MS Complaint #17473 was substantiated with an Immediate Jeopardy and Substandard Quality of Care (SQC) related to pressure sores and medication administration identified on 05/20/21 and determined to begin on 11/17/20 when the facility failed to administer medications as ordered to a COVID -19 positive resident and the resident was hospitalized and subsequently died. B. MS Complaint #17430 was substantiated with an Immediate Jeopardy and Substandard Quality of Care (SQC) identified on 05/20/21 and determined to begin on 03/17/21 when a resident with known aggressive behaviors was admitted to the facility and physically and verbally abused other residents. The facility failed to report this allegation of abuse. C. MS Complaint #17381 was substantiated with an Immediate Jeopardy and Substandard Quality of Care (SQC) identified on 05/20/21 and determined to begin on 04/06/21 when the facility failed to assess, treat, and prevent infection and worsening of pressure ulcers. D. MS Complaint #17774 was substantiated with an Immediate Jeopardy and Substandard Quality of Care (SQC) identified on 05/20/21 and determined to begin on 04/25/21 when the facility failed to use a lift to transfer a resident	M 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 000	Continued From page 1 careplanned for the use of a lift resulting in the resident sustaining a fracture of the tibia. The facility also failed to report this event. The regulatory requirements that constitute the Immediate Jeopardy were as follows: M075 Governing Body M225 Sufficient Nursing Staff M350 Administration M500 Resident Rights M615 Pressure Ulcers M630 Behavioral Health Services M745 Pharmacy Services M735 Resident Records The facility's Administrator was notified of the Immediate Jeopardy and SQC on 05/21/21. Due to the magnitude of the systemic regulatory noncompliance with Medicare and Medicaid participation requirements, the State Agency determined the facility was unable to provide evidence of systemic corrections to remove the Immediate Jeopardy (IJ) prior to exit from the facility and therefore, the Immediate Jeopardy is considered ongoing.	M 000		
M 075	45.2.10 Governing Authority Governing Authority. The term "governing authority" shall mean owner(s), Board of Governors, Board of Trustees, or any other comparable body duly organized and constituted for the purpose of owning, acquiring, constructing, equipping, operating and/or maintaining a facility, and exercising control over	M 075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 075	Continued From page 2 the internal affairs of said facility. This Statute is not met as evidenced by: Widespread Jeopardy Level CI 17430, CI 17473, CI 17381, CI 17774 Based on an interview the governing body failed to act on information reported by the facility's 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	M 075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 075	Continued From page 3	M 075		

regarding operation of the facility to decrease the likelihood of serious injury, harm, impairment, or death.

This situation was determined to be an Immediate Jeopardy (IJ) on 5/21/21 and was determined to exist on 11/17/2020. The IJ was not removed prior to exit on 5/26/21 and is considered ongoing.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 075	Continued From page 4 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.	M 075		
M 225	45.4.1 Nursing Facility Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements: 1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio. 2. Each facility shall have the following licensed personnel as a minimum: a. Seven (7) day coverage on the day shift by a registered nurse. b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day shift and be responsible for all nursing services in the facility. c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse.	M 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 225	Continued From page 5 d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse. e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse. f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse. 3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. 4. There shall be at least two (2) employees in the facility at all times in the event of an emergency. This Statute is not met as evidenced by: Widespread Jeopardy Level 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 (Residents #1, #5, #8, #10, #11, #12,#15 and #17), delay in incontinent care (Resident #8),	M 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 225	Continued From page 6	M 225		

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.

F725 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 was not removed prior to exit on 05/26/2021 and is considered ongoing.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 225	Continued From page 7 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 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 AM 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	M 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 225	Continued From page 8	M 225		

#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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 225	Continued From page 9	M 225		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 225	Continued From page 10	M 225		

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 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 AM 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 225	Continued From page 11 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. 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.	M 225		
M 350	45.12.1 Reponsiblility	M 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 350	Continued From page 12 1. There shall be a licensed administrator with authority and responsibility for the operation of the facility in all its administrative and professional functions subject only to the policies enacted by the governing authority and to such orders as it may issue. The administrator shall be the direct representative of the governing authority in the management of the facility and shall be responsible to said governing authority for the proper performance of duties. 2. There shall be a qualified individual present in the facility responsible to the administrator in matters of administration who shall represent him during the absence. The persons shall not be a resident of the facility. This Statute is not met as evidenced by: Widespread Jeopardy Level MS CI #17430, #17473, #17381, #17774 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 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	M 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 350	Continued From page 13 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. 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: 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	M 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 350	Continued From page 14 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 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	M 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 350	Continued From page 15	M 350		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 350	Continued From page 16	M 350		

deficient practice started from the COVID-19 pandemic with the prior DON because the facility did not have enough staf
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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 350	Continued From page 17 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 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.	M 350		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 18 and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 19 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 20	M 500		

monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

14. may retain and use his personal clothing and possessions as space permits, unless to do so

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 21 would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Widespread Jeopardy Level 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 failed to ensure staff followed the no manual lift policy.The facility also failed to follow the two (2) persons assist with transfers using the mechanical lift which resulted in major injuries for Resident #2 and Resident #14. The facility failed ensure residents were protected from abuse and neglect for five (5) of 29 residents reviewed for abuse and neglect. The facility's failure to ensure a resident's right to	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 22	M 500		

be free from abuse and neglect, 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 begin on 3/17/21 when Resident #1 was admitted to the facility and physically and verbally abused other residents.

The IJ was not removed prior to exit on 5/26/21 and is considered ongoing.

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 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.
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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 23	M 500		

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 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 or impaired

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 24	M 500		

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.

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 for psychosis.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 25 Observation 5/4/21 at 1:14 PM of 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 attempting to redirect the resident and was unsuccessful. Resident #1 approached the State Agency (SA) poking 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 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 she 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 this resident. 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 26	M 500		

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).

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, DON, Assistant Director of Nursing (ADON) and Admissions Director discussed Resident #1's behavior. 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 27	M 500		

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 #4 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 28	M 500		

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, CNA #7 said 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 he walks up to the other residents' face and shake his fist at them. Resident #1 pushes the residents as well. CNA #7 said all the residents are afraid of Resident #1.

On 5/5/21 at 12:00 PM, in an interview with CNA #7, revealed he works on the 7-3 shift. He stated Resident #1 is hard to redirect and fights the staff when they attempt to provide care. He stated Resident #1 continually curses at the staff and residents and is impulsive. Resident #1 walks up to the other residents and shakes his fist in their faces and pushes the residents. CNA #7 reported the residents are afraid of Resident #1.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 29 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 done 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 department with the corporate office, BOM and the Administrator decides what 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 Psych Nurse Practitioner (NP) said 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 assessed and monitored 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 visiting the residents twice a week. The Psych (NP) said she will review all Residents that are 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 30	M 500		

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

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
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 31	M 500		

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 13:03, 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 32	M 500		

(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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 33	M 500		

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:

*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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 34	M 500		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 35	M 500		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 36	M 500		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 37 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 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 38	M 500		

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 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 39	M 500		

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 with 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 lift facility. CNA #4 stated the facility requires two (2) people with all lifts. CNA #4 stated it has been over a 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 40	M 500		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 500	Continued From page 41 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 e	M 500		
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Widespread Jeopardy Level 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	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 42	M 615		

(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 fowl 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.

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 43 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." 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.	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 44 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 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	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 45	M 615		

(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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 46	M 615		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 47	M 615		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 48 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 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	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 49	M 615		

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 50	M 615		

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 51 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 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	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 52	M 615		

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 53	M 615		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 54 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 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."	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 55 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. 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	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 56	M 615		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 57 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 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	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 58	M 615		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 59	M 615		

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 60	M 615		

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 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. He explained 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 615	Continued From page 61 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 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 M	M 615		
M 630	45.21.6 Mental and psycho-social	M 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 630	Continued From page 62 Mental and psycho-social. A resident who displays adjustment difficulty receives appropriate treatment and services to address the assessed problem. This Statute is not met as evidenced by: Widespread Jeopardy Level CI 17430 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 as not removed prior to exit on 5/26/21 and is considered ongoing. 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	M 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 630	Continued From page 63	M 630		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 630	Continued From page 64	M 630		

performance deficit related to aggressive behavior and confusion.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 630	Continued From page 65	M 630		

have any behavioral health training. The DON 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
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 630	Continued From page 66 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 might hurt one of the vulnerable residents on the	M 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 630	Continued From page 67	M 630		

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 visiting the residents twice a week. The Psych (NP) said she will review all Residents that is on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 630	Continued From page 68	M 630		

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, Mood disorder and Psychosis. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/26/21, revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 630	Continued From page 69 Resident #1 had a Brief Interview for Mental Status (BIMS) of 00 indicating Resident #1 is cognitively severely impaired.	M 630		
M 700	45.24.1 General General. The facility shall provide routine drugs, emergency drugs and biologicals to its residents or obtain them by agreement. This Statute is not met as evidenced by: Widespread Jeopardy Level MS #17430 MS #17473 MS #17381 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 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	M 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 70	M 700		

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 was not removed prior to the State Agency (SA) exit on 5/26/2021 and is considered ongoing.
The IJ and Substandard Quality of Care (SQC) existed at CFR(S): 483.55(a)- Pharmaceutical Procedures.

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 services 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 71	M 700		

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 72	M 700		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 73	M 700		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 74	M 700		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 75	M 700		

- 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 76	M 700		

(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, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 77 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 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)	M 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 78 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 (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	M 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 79 (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. Record Review of Resident #7's Physician Orders revealed the following Physician Orders:	M 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 80	M 700		

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:
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 81 (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 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	M 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 82	M 700		

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 related to Bipolar Disorder (8/8/19)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 83	M 700		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 84 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) 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)	M 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 85 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. Resident #16 Record review the Admission Record reveals Resident #16 was admitted to the facility on	M 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 86 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) 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)	M 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 87	M 700		

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)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 88	M 700		

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 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 89	M 700		

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 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,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 700	Continued From page 90 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) 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,	M 700		
M 735	45.25.1 Medical Records Management Medical Records Management.	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 735	Continued From page 91 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records.	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 735	Continued From page 92 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute is not met as evidenced by: Widespread Jeopardy Level 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:	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 735	Continued From page 93 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 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.	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 735	Continued From page 94 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, 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,	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 735	Continued From page 95 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 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	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 735	Continued From page 96	M 735		

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 735	Continued From page 97	M 735		

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 735	Continued From page 98 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'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.	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 735	Continued From page 99	M 735		

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 735	Continued From page 100 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 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	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 735	Continued From page 101 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 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,	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 735	Continued From page 102 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 foot.	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	C 05/26/2021

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) COMPLETE DATE
M 735	Continued From page 103 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.	M 735		