STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	11/26/2019

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

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey from 11/24/19 through 11/26/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid Requirements of participation. The SA cited deficiencies at F623, F641, F656, and F812. The facility was licensed for 80 beds, and had a census of 64 at the time of survey.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		1/6/20

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

Electronically Signed | 12/20/2019

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F 623	Continued From page 1 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with	F 623		

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F 623	Continued From page 2 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review the facility failed to notify the Resident Representative, in writing, of a resident's transfer to the hospital, for two (2) of four (4) residents reviewed for hospitalization. Resident #50 and #22. Findings include:	F 623	1. Resident #50's responsible party was notified of hospital transfer by phone on 10/20/19. A message was left on the responsible party's voice mail. Written documentation was completed at the time of transfer and maintained in the Social Service office at the time of transfer.The facility forwarded a written notification	

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F 623	Continued From page 3 Review of the "Notice of a Transfer and/or Discharge" policy, dated 2/26/03, revealed: Policy Statement: This policy applies to transfers or discharges initiated by the facility. By definition, transfer or discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. The resident, and/or representative will be provided with the reason for the transfer or discharge, the effective date of the transfer or discharge, and the location to which the resident is being transferred or discharged. Upon such transfer, the facility must provide written notice to the resident and an immediate family member, surrogate or representative. Resident #50 A review of Resident #50's "Order Review Report" revealed a physician's order, dated 10/20/2019, to send to local hospital Emergency Room (ER) for evaluation. A review of the Progress Notes, dated 10/19/2019, revealed Resident #50 had a change of mental status , was unable to ambulate and slow to respond. The Responsible Party was unable to be reached, and message was left. Nurse Practitioner was notified, and ordered to send the resident to (Name of Hospital) ER for further evaluation. A record review of Resident #50's Minimum Data Set (MDS), Entry Tracking Record, revealed the most recent re-entry to the facility (Section A1600) was on 10/23/2019, from an acute hospital.	F 623	(late) to the responsible party on December 17, 2019, to meet the regulatory requirements for 483.15(c). Resident #22 responsible party was notified by phone of transfers to the hospital on 7/29/19, 9/3/19 and 11/9/19. Resident #22's responsible party acknowledged transfer to hospital via telephone. Written documentation was completed and maintained in the Social Service office on each transfer. The facility forwarded a written notification(late) to the responsible party on December 17, 2019, to meet the regulatory requirements for 483.15(c. 2. Residents transferred or discharged from the facility have the potential to be affected by the alleged deficiency. 3. On 11/27/19 the Social Service Director was in serviced on the regulatory requirements of notification for hospital transfers/discharges by the Administrator. The Director of Nursing in serviced nursing staff beginning on December 16, 2019 and will continue for all on procedures to notify responsible parties of residents of transfers and discharges. The instructions included for nursing staff to notify the Social Service Director of hospital transfers. 4. The Director of Nursing and/or the Administrator will review the notification process for four(4) weeks. Results will be reported to the Quality Assurance	

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F 623	Continued From page 4 During an interview, on 11/25/19 at 11:29 AM, the Assistant Director of Nursing (ADON)/Registered Nurse (RN) #2 revealed Resident #50 was sent to the hospital for abnormal vital signs (10/20/19). Further interview on 11/26/19 at 9:21 AM, the ADON revealed the facility should notify the Responsible Party (RP) by mail of any transfer to the facility. On 11/25/19 at 12:17 PM, an interview with the Social Services Director (SSD), revealed he was informed he only needed to phone the RP, instead of mailing a written notice of why the resident was transferred to the hospital. Resident #22 During an interview and record review, on 11/25/19 at 3:45 PM, LPN #1 stated Resident #22 was transferred/hospitalized on 9/3/19 due to abdominal wall infection, on 11/9/19 due to chest pain, and was transferred to the ER on 7/29/19. During an interview on 11/25/19 at 3:59 PM, the Social Services Director (SSD) confirmed he did not mail a letter to the representative related to Resident #22's discharge to the hospital three (3) times. He stated he did not know how to do it. During an interview on 11/26/19 at 9:21 AM, the ADON revealed the facility should notify the Responsible Party (RP) by mail of any transfer to the facility.	F 623	Committee monthly. The Quality Assurance Committee will be responsible for determining the continued need for reviews.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		1/6/20

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F 641	Continued From page 5 by: Based on record review, staff interview, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) related to an anti-coagulant medication for Resident #32, and dehydration for Resident #31; for two (2) of 15 residents MDS assessments reviewed. Findings include: A review of the facility's "Resident Assessment" policy, dated June 1, 2000, revealed: Information derived from the comprehensive assessment enables the staff to plan care that allows the resident to reach his/her highest practical level of functioning. (Indicates the assessment should be accurate.) Resident #31 Record review of Resident #31's Annual MDS Assessment, with an Assessment Reference Date (ARD) of 10/8/19, revealed, dehydrated was a problem checked. On 11/25/19 at 10:51 AM, an interview with the ADON/RN #2, revealed, Resident #31 is able to feed himself and hold his drinks by himself. She stated the facility offers fluids, has a hydration cart at 10:00 AM and 2:00 PM, and the facility keeps ice and water in the resident's room at all times. She stated Resident #31 has not had any problems with hydration that she is aware of. Record review revealed Resident #31's had no lab results indicating dehydration and no documentation of signs and symptoms of dehydration during the 10/8/19 MDS assessment period.	F 641	1. An assessment modification was completed for Resident #31 on November 26, 2019, by Minimum Data Set nursing staff to correct the incorrect code of Section J. This corrected Resident #31's Comprehensive Minimum Data Set assessment with a reference date of 10/8/19. An assessment modification was completed for Resident #32 on November 26, 2019, by Minimum Data Set nursing staff to correct the incorrect code of Section N. This corrected Resident #32's Comprehensive MDS assessment with a reference date of 10/9/19. 2. Residents requiring comprehensive assessments have the potential of being affected by this alleged deficiency. 3. An in service was conducted on November 26, 2019, by the Regional Nurse Consultant to educate the Minimum Data Set nursing staff on consulting the Resident Assessment Instrument manual regarding Section J and Section N for Comprehensive assessments. An audit was completed by the Minimum Data Set nursing staff for all comprehensive assessments completed. Corrections and modifications were completed on incorrect entries on November 26, 2019, by the Minimum Data Set nursing staff for comprehensive assessments. Five submissions were modified for corrections. These were	

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F 641	Continued From page 6 On 11/26/19 at 11:45 AM, an interview with RN #1, revealed, she coded the 10/8/19 Annual MDS assessment for dehydration, and it should not have been coded, because the resident was not dehydrated. RN #1 stated the MDS assessment was not accurate. Resident #32 A review of the most recent Annual MDS Assessment, with an ARD of 10/9/19, was coded to include an anticoagulant medication. A review of the physician orders, dated October 2019, revealed, Resident #32 did not have an anticoagulant medication ordered. During an interview, on 11/26/19 at 10:04 AM, RN #1 stated the MDS was not coded accurately, because the resident was not on an anticoagulant medication at the time the MDS was completed. She also stated she is still learning and uses a sheet that she was given to her by the other MDS Nurse/Licensed Practical Nurse (LPN) #2 to code the medications. RN #1 stated she uses the Resident Assessment Instrument (RAI) manual as a guideline to code the MDS. On 11/26/19 at 10:52 AM, an interview with the Administrator, revealed, she would expect the MDS Nurses to complete the MDS, and to complete them accurately.	F 641	submitted and accepted on November 27, 2019. Through the audit of November 26, 2019, six (6) residents were revealed to be on the medication Plavix. Corrections to the medication coding were completed for the residents discovered by the Minimum Data Set nursing staff. The Minimum Data Set nursing staff will review Sections J prior to all submissions to insure accurate diagnosis is submitted for all comprehensive assessments due. The Minimum Data Set nursing staff will review Section N prior to all submissions to insure accurate coding of medication for all comprehensive assessments due. The Resident Assessment Instrument manual will be used for guidance for accurate assessments and accurate medication coding. 4. Minimum Data Set submissions will be reviewed for four (4) weeks by the Director of Nursing for accuracy of Section J and Section N on all comprehensive assessments. The Director of Nursing will report findings to the Quality Assurance Committee monthly. The Quality Assurance Committee will be responsible in determining the length of time MDS are to be reviewed. It will be the responsibility of the Quality Assurance Committee to deem the issue resolved.	

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		1/6/20

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F 656	Continued From page 8 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review the facility failed to develop a Comprehensive Care Plan, related to Hospice, for one (1) of 17 residents' care plans reviewed, Resident #3. Findings include: Review of the facility's "Care Plans-Comprehensive" policy, dated 1/2/00, revealed: It is the policy of this facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetable to meet the resident's medical, nursing, and psychological needs. Review of Resident #3's Initial Comprehensive Care Plan, revealed, no care plan for Hospice services. Review of the physician orders, dated 8/20/2019, revealed Resident #3 was admitted to Hospice services. Review of Resident #3's initial Comprehensive Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/27/2019, revealed, Hospice Care was checked. During an interview, on 11/25/19 at 10:49 AM, the Social Services Director (SSD) and License Practical Nurse (LPN) #2/MDS Coordinator, both revealed Hospice Care is not included and/or	F 656	1. Resident #3's Comprehensive Care Plan was updated to reflect hospice services on November 26, 2019, by facility Minimum Data Set nursing staff. 2. Residents receiving hospice services have the potential to be affected by this alleged deficiency. 3. An in service was conducted on December 17, 2019, by the Director of Nursing with the Social Service Director and Minimum Data Set nursing staff to educate on the importance of including plans of care for residents receiving hospice services. Individuals receiving hospice services within the facility will have their care plans reflect hospice services. The Social Service Director will initiate the hospice care plan. The Minimum Data Set nursing staff will review to insure the care plan is present for those residents receiving hospice services within the facility. 4. The Director of Nursing and/or the Assistant Director of Nursing will review care plans to insure the care plans reflect hospice services received by residents of the facility. They will review care plans weekly for four (4) weeks for both skilled	

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F 656	Continued From page 9 incorporated in Resident #3's Care Plan. During an interview, on 11/25/2019 at 11:30 AM, the Assistant Director of Nursing (ADON), revealed, Hospice Care was not included in Resident #3's Care Plan; it must have been overlooked.	F 656	and non skilled residents. Care plans will be continuously reviewed for all residents admitted with hospice services. Findings of the review will be reported to the Quality Assurance Committee by the Director of Nursing monthly. The Quality Assurance Committee will be responsible in determining the resolution of this issue.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility's staff failed to wear hair nets to prevent food-borne illnesses. The facility also failed to separate the dented cans, and label/date received and stored	F 812	1. Dietary Aide #1 and Cook #1 put hair nets on 11/24/19. The 7# can of chocolate pudding was removed from the canned goods section	1/6/20

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F 812	Continued From page 10 foods; for one (1) of two (2) dietary tours. Findings include: Review of the facility's "Staff Attire" policy, revised 09/17, revealed: All staff will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. Review of the facility's "Receiving" Policy Statement, revised 09/17, revealed: All can goods will be appropriately inspected for dents, rust or bulges. Damaged cans will be segregated and clearly identified for return to vender or disposal, as appropriate. All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation by staff. An initial tour of the dietary department, on 11/24/19 at 1:50 PM, revealed, Dietary Aide #1 and Cook #1 was observed in the kitchen, with no hair net in place. Review of the food storage room revealed one (1) 7-pound can of dented chocolate pudding, in the canned goods section. An observation, inside of the cooler, revealed a container of apple cobbler without a date or name on the container, a plastic container of corn bread without a date or name. There were 16 cases of water, two (2) boxes of coffee and tea , 23 loaves of white sandwich bread, 13 packs of hamburger buns, without a received date on them. During an interview, on 11/24/19 at 2:20 PM, Cook #1 stated hair nets should be worn at all times; we just didn't put them on. Cook #1 stated it could cause contamination of food. She also stated dented cans should have been removed and put in the dented can section, in the	F 812	to the designated area for damaged goods on 11/24/19 by Cook #1. The container with apple cobbler was discarded on 11/24/19 by the Dietary Manager. The container holding the cornbread was dated on 11/24/19 by the Dietary Manager. The sixteen (16) cases of water, two (2) boxes of coffee and tea, the twenty-three (23) loaves of white sandwich bread and thirteen (13) packages of hamburger buns were dated with receipt dates on 11/24/19 by the Dietary Manager. 2. Individuals receiving meals prepared in the facility dietary department have the potential to be affected by this alleged deficiency. 3. An in service was conducted on November 25, 2019,by the Divisional Director of Health Care Services to educate dietary staff with regards to appropriate hair restraint. An in service was conducted by the Dietary Manager on November 26, 2019, to educate dietary staff of the regulatory requirements for dating incoming supplies to include receipt of goods. An in service was conducted by the Dietary Manager on November 26, 2019, to educate dietary staff on the importance of separating damaged goods/food form usable goods/food to prevent contamination.	

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F 812	Continued From page 11 storage room. Cook #1 stated, the items without a date, came in Thursday, and should have been put up and dated by now. During an interview, on 11/24/19 at 2:40 PM, the Dietary Manager (DM) revealed, staff have been trained to wear hair nets at all times, because not wearing hair nets in the kitchen can contaminate the food. The DM stated dented cans should be moved to the dented can section. Upon delivery, all food should be dated and stored. The DM stated food needs to labeled and dated, when it is put in the cooler; this prevents food being given to residents, which could be spoiled.	F 812	4. The Administrator will be responsible for inspection of cooler, the food storage areas and dietary staff. The inspections will be conducted two (2) times per week for four (4) weeks to insure proper hair restraints, correct dating and proper storage of damaged goods/food. Findings will be reported to the Quality Assurance Committee by the Administrator monthly. The Quality Assurance Committee will be responsible to determine if the issue has been corrected and resolved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING **01 - BUILDING 0101** B. WING _____	**11/24/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to properly maintain exit egress as per NFPA 101 section 19.2.2.2.6. This deficiency practice affected one (1) of seven (7) exits and 11 of 66 residents in facility on day of survey. Findings include: On November 24, 2019 at 2:40 PM, observation revealed hay bales and other holiday decorations obstructing the means of egress to the Main Entrance of the facility.	K 211	1. The hay bales and holiday decorations were removed from the facility porch area on 11/24/19 by the Maintenance Supervisor. 2. All egress areas were inspected. The main egress area was determined to be the only area affected by this alleged deficiency. 3. The Maintenance Supervisor conducted an in service on November 27, 2019, with the Life Connection (Activities) staff to educate them on regulatory code CFR: NFPA101, means of egress. 4. The Maintenance Supervisor and Housekeeping Supervisor will be	1/6/20

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

Electronically Signed | 12/20/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING **01 - BUILDING 0101** B. WING _____	**11/24/2019**

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K 211	Continued From page 1	K 211	responsible to observe exit egresses for building daily. The maintenance supervisor shall report any obstructions noted to egresses to the Administrator following clearing them. The Administrator will report to the Quality Assurance Committee unfavorable findings. The Quality Assurance Committee will be responsible for recommendations if deemed necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	11/24/2019

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E 000	Initial Comments ********** Survey conducted on 11/24/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.