| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted an annual recertification survey and a Complaint Investigation (CI), MS #26192, at the facility from 08/19/2024 through 08/22/2024. The SA investigated CI MS #26192 for Physical Environment related to equipment not maintained and Quality of Care related to resident safety and cited F684. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550, F582, F695, F812, and F880.<br><br>The facility held a license for 80 beds and the census at the time of the survey was 71. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and | F 550 | | 9/19/24 |

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

Electronically Signed | 09/12/2024

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 550 | Continued From page 1<br>practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and facility policy review, the facility failed to assist a resident with eating in a dignified manner during a dining observation, as evidenced by a Certified Nurse Aide (CNA) was observed standing over a resident while assisting the resident to eat during one (1) of two (2) meal observations. Resident #21<br><br>Findings Include:<br><br>A review of the facility's policy titled "Resident Rights," revised and implemented 11/28/16, revealed, " ...The resident has a right to a dignified existence ...A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment | F 550 | F550<br>" Certified Nursing Assistant (CNA) #1 was in-serviced by the Director of Nursing on resident rights and dignity on 8/22/2024. Resident #21 was assessed by the Director of Nursing (DON) and no harm was found.<br>" All residents that require assistance with meals have the potential to be affected.<br>" All nursing staff were in-serviced by the Assistant Director of Nursing (ADON) on 8/22/2024 on resident rights and dignity. On 8/22/2024, the Housekeeping Supervisor performed an audit of all rooms in the building, and any room without a chair at bedside there was one | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 550 | Continued From page 2<br>that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident ..."<br><br>On 08/22/24 at 8:50 AM, during a dining observation, CNA #1 was observed standing while feeding Resident #21.<br><br>On 08/22/24 at 9:05 AM, during an interview, CNA #1 acknowledged she was standing while feeding Resident #21. CNA #1 stated she was aware the proper way to assist a resident with feeding is to sit. CNA #1 reported she was not trained to sit during assisted feeding at this facility but had learned the importance of sitting while assisting residents while eating from her years of experience as a CNA.<br><br>On 08/22/24 at 9:16 AM, during an interview, the Director of Nursing (DON) stated that CNAs are trained to position themselves in front of the residents, observe, and make eye contact during assisted feeding. The DON reported that the staff should not be standing while feeding but may sit depending on the resident's level. The DON confirmed that her expectation is to ensure the staff are trained to sit while performing assisted feedings.<br><br>On 08/22/24 at 12:52 PM, during an interview, the Administrator acknowledged that a staff member had assisted the resident in feeding while standing. The Administrator stated that the staff would be in-serviced on the proper way to assist the residents in feeding.<br><br>A record review of the facility's "Admission Record" revealed the facility admitted Resident | F 550 | placed.<br>" The Quality Assurance Performance Improvement (QAPI) Team met on August 22, 2024, and discussed the possibility of the negative outcome of the CNA, and the deficient practice found, reviewed the policy and procedure with no changes deemed necessary. The Director of Nursing and Assistant Director of Nursing will begin monitoring of staff during feeding 2 meals per resident per for 12 weeks began on August 23, 2024, and will continue for 12 weeks. The monitoring for the audit will be brought before the QAPI team monthly for monitoring and recommendations. The next QAPI meeting will be September 18, 2024, and this monitoring will continue for 3 months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 550 | Continued From page 3<br>#21 on 12/28/17. The resident's diagnoses included Vascular Dementia, Unspecified Severity, with Other Behavioral Disturbances, and Dysphagia, Pharyngoesophageal Phase.<br><br>A record review of Resident #21's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/29/24 revealed a Brief Interview for Mental Status (BIMS) should not be conducted. Further review revealed the staff's assessment of the resident's cognitive status indicated the resident was severely impaired regarding cognitive skills for daily decision making. | F 550 | | |
| F 582 SS=D | Medicaid/Medicare Coverage/Liability Notice<br>CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those | F 582 | | 9/19/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 582 | Continued From page 4<br>services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews, and facility policy review the facility failed to provide the Notice of Medicare Non-Coverage letter indicating the resident was notified prior to Medicare coverage ending for two (2) of three (3) residents reviewed for beneficiary protection notification. (Resident #12 and Resident #34) | F 582 | F 582<br>" Residents #12 and #34 will be mailed Advanced Beneficiary Notices (ABN). The ABN□s will be filled out by the Business Office Manager three days prior to a resident□s discontinuation of services beginning effective immediately on August 19, 2024, to prevent a negative outcome. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 582 | Continued From page 5<br>Findings Include:<br><br>Review of the facility's policy titled, "Medicare Advanced Beneficiary Notice," with a review date of 7/24/23, revealed "Residents are informed in advance when changes will occur in their bills. If the interdisciplinary team believes (upon admission or during the resident stay) that Medicare (Part A of the fee for service Medicare Program) will not pay for an otherwise covered skilled service(s), the resident (or representative) is notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s) ..."<br><br>Resident #12<br><br>Record review of the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review with a start date of 1/30/24 revealed last covered day of Part A Service was 2/22/24. However, the resident has remained in the facility.<br><br>Record review Resident #12's "Advance Beneficiary Notice of Non-coverage" revealed the last covered treatment was 5/31/24. This document was not dated or signed by the resident or Resident Representative (RR).<br><br>Review of the "Admission Record" of Resident #12 revealed the facility admitted the resident to the facility on 1/30/24. The resident's diagnoses included Chronic Obstructive Pulmonary Disease, Parkinson's Disease, without Dyskinesia, and Heart Failure.<br><br>Resident #34<br><br>Record review of the SNF Beneficiary Protection | F 582 | " All Medicare residents in the facility with Medicare benefits have the potential to be affected.<br>" In-services were conducted by the Regional Director of Operations for the Administrator, Business Office Manager, and the Director of Nursing on August 19, 2024. The social worker Minimum Date Set (MDS) nurses, Assistant Director of Nursing (ADON) and Director of Nursing (DON) were also educated on the proper policy and procedure to complete ABN forms and why. A complete audit was completed on ABN forms for all eligible residents on 8/20/2024 by the Business Office Manager. Upcoming discharges will be addressed in the morning standing up meeting while addressing the needs and discharge planning of residents receiving skilled services.<br>" Daily Clinical meetings will monitor, acknowledge and discuss upcoming discharges to allow staff time for proper notification to the Residents and/or Responsible Party of Advance Beneficiary Notice Non-Coverage forms beginning August 20, 2024, and will continue 12 weeks. These forms will be monitored and reviewed in the monthly Quality Assessment Performance Improvement team meetings. The first QAPI meeting was on August 22, 2024, and the next QAPI meeting will be conducted on September 18, 2024. This completion date for corrective action is September 19, 2024 for 3 months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 582 | Continued From page 6 | F 582 | | |

Notification Review with a start date of 2/5/24 revealed last covered day of Part A Service was 3/1/24.

Record review Resident #34's "Advance Beneficiary Notice of Non-coverage" revealed the last covered treatment was 4/10/24. This document was not dated or signed by the resident or RR.

Review of the "Admission Record" for Resident #34 revealed the facility admitted the resident to the facility on 2/5/24. The resident's diagnoses included Malignant Neoplasm of Unspecified Part of Unspecified Bronchus or Lung and Adult Failure to Thrive.

On 8/22/24 at 11:12 AM, in an interview with the Business Office Manager/Human Resources staff she stated she started working at the facility 8/12/24 and has had previous experience and knowledge of completing the Beneficiary Forms. She stated the forms are reviewed with the resident or RR a week before coverage ends and at that time, she gets them to sign it showing that they were informed. She stated the reason for it is to let the resident and the family know their options. She stated it should always be signed, it shows they were informed of options and coverage. She stated if the RR did not come to the facility, she would send it in a certified letter for them to sign upon receipt.

On 8/22/24 at 12:49 PM, in an interview the Administrator he stated he became aware of the notices not being done according to policy upon the State Agency (SA) entrance to the facility. He stated he has already put things in place so that it will not happen again. He stated he expects his

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 582 | Continued From page 7<br>staff to follow policy. | F 582 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interviews, the facility failed to provide safe, functional transportation that ensured a reasonably comfortable environment for residents during transport for one (1) of 21 sampled residents. Resident #52<br><br>Findings Include:<br><br>During an interview on 08/19/24 at 11:14 AM, Resident #52 revealed that on 08/12/2024, he was transported two hours away from the facility in a transport van that did not have functioning air conditioning. He stated that during the morning transport, it was hot and stuffy, but not as bad as the afternoon ride back to the facility. He described the van as having no real windows in the back that could open, only two small vents that did not allow much air to circulate, making the trip "very uncomfortable." As a quadriplegic, he was unable to fan himself, which added to his discomfort. He stated that on the ride home in the afternoon, the van "was very hot", and he became | F 684 | F684<br>• Resident #52 complained of being hot and very uncomfortable during a trip on 8/12/2024. Resident #52 was returned to the facility. The resident's nurse immediately checked the resident's vitals which were within normal limits upon return. Resident was offered hydration, snacks, shower, and change of clothing. The air conditioner in the facility van was fixed the morning of August 13, 2024, before any residents were transported.<br>• All residents who transport in the facility van had the potential to be affected by the heat.<br>• The two van drivers for the facility have been in-serviced on resident safety and van assessment before any resident transfers. Check lists were provided and reviewed by both drivers. Drivers have been instructed to cancel, reschedule, or call for alternate means of resident transport if any system on the facility van | 9/19/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 8<br>very sweaty and lightheaded. He contacted his mother via video call, who noticed he was sweaty. Resident #52 told her he felt "hot and weak." She advised the bus driver to pull over and give him some water that she had given him during the appointment. Resident #52 expressed that he felt the situation was handled improperly on the part of the Administrator, as no apology or explanation had been provided.<br><br>A record review of the www.weatherunderground.com historical weather revealed the high temperature for 8/12/24 was 95 degrees.<br><br>An interview with the transportation driver on 08/20/24 at 1:10 PM, revealed that the facility's transportation van had been without functioning air conditioning from 08/08/2024 through 08/13/2024. She stated that she informed the Administrator on 08/08/24 about the air conditioning issue but was instructed to continue transporting residents to their appointments, including Resident #52's appointment almost two hours away from the facility on 08/12/2024. She confirmed that during the return trip, the resident appeared "hot and flushed", and she reported this to the nursing staff upon returning to the facility.<br><br>During an interview on 08/20/24 at 01:30 PM, Resident #52's family member revealed that she met her son at his appointment on 08/12/2024 and noticed that he was hot and sweaty. The driver informed her that the air conditioning in the van was out, but she had been told to transport the resident to his appointment regardless. During the ride home, her son called her and stated that he was hot, and she noticed he was sweaty during the video call. She asked the driver | F 684 | is inadequate or non-functioning. The Drivers have been instructed to notify the Administrator and the DON immediately or other members of the management time in the event he or she can't be reached. The van drivers have been instructed to check for any issues with the facility van before taking a resident to an appointment etc.<br>• The drivers will monitor the tires, gauges, heat/air, and other noted areas of concern on the check list of the company's fleet safety guidelines on 8/26/2024 for 12 weeks. The Administrator will monitor the driver's records and inspect the van weekly beginning 8/26/2024, for 3 months. The Quality Assessment Performance Improvement team will monitor fleet logs monthly to ensure that maintenance and safety expectations are met beginning 8/22/2024 to be continued monthly to monitor safety and maintenance logs. This will be monitored at next QAPI meeting will be held 9/18/2024 and will be monitored monthly for 3 months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 9<br>to pull over and give her son some water that she had left with him. She reported the incident to the Ombudsman and the nursing home Administrator.<br><br>In an interview with the Licensed Nursing Home Administrator (LNHA) on 08/21/24 at 11:14 AM, it was revealed that on the day of the incident, most of the administrative nurses, including himself, were out of the building for training sessions. He stated that he did not recall whether he had prior knowledge of the air conditioning issue but did receive a phone call on 08/12/2024 about it. He instructed the transportation driver to make an appointment to have the van repaired. The Administrator confirmed that the van was repaired on 08/13/2024 and acknowledged the resident's family member had contacted him via text message from the resident's mother.<br><br>A record review of the "Admission Record" revealed that the facility admitted the Resident #52 on 1/25/2024, and he had current diagnoses including Quadriplegia and Hyperhidrosis (excessive sweating).<br><br>A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/28/2024 revealed Resident #52 had a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated he was cognitively intact. | F 684 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning<br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who | F 695 | | 9/19/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 695 | Continued From page 10<br>needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to store and date respiratory equipment in a manner that prevented possible cross-contamination and consistent with professional standards of practice, as evidenced by, undated tubing and a face mask not being bagged when not in use, for two (2) of four (4) observations. Resident #171.<br><br>Findings Include:<br><br>A record review of the facility's "Oxygen Administration" policy, dated August 25, 2014, revealed "Purpose: The purpose of the procedure was to provide guidelines for safe oxygen administration ..." The policy did not address handling and storage of oxygen tubing.<br><br>On 08/19/24 at 11:41 AM, an observation of Resident #171 revealed that the oxygen tubing attached to the resident was not dated, and the face mask, which was not in use, was hanging from the wall and not placed in a bag.<br><br>On 08/20/24 at 8:50 AM, duirng an observation revealed the oxygen tubing attached to Resident #171 remained undated, and the face mask, still not in use, continued to hang from the wall without being bagged.<br><br>Record review of Resident #171's Order | F 695 | F 695<br>" Resident #171 was observed on 8/19 and 20/2024 that the oxygen tubing was not dated and the O2 mask was hanging from the wall and not placed in a plastic bag while not in use. There were no negative outcomes. All Oxygen tubing was changed and dated by the nurses on 8/20/2024.<br>" All residents that reside in the facility with Oxygen tubing had the potential to be affected.<br>" The Director of Nursing (DON) and Assistant Director of Nursing (ADON) created a sign off sheet to be completed after tubing is changed and dated weekly. In-services were conducted with Licensed Nurses and Certified Nurse□s Assistants for education on the correct policy and procedures defining which days tubing is to be changed, date placement, and proper storage of the mask while not on the resident□s face by the DON and ADON. The documentation of tubing replacement, dating the tubes, and proper storage of equipment not in use began on 8/22/2024 in the facility health care information system, Point Click Care.<br>" Quality Assurance Performance Improvement (QAPI) was conducted on 8/22/2024 to educate staff on policy and | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 695 | Continued From page 11<br>Summary Report with active orders as of 8/22/24, revealed an order dated 7/23/24 " O2 (oxygen) BNC (by nasal cannula) at 4 LPM (liters per minute) cont. (continuously) every shift related to Chronic Obstructive Pulmonary Disease with Acute Exacerbation (J44.1)."<br><br>Record review of an order dated 3/11/24 revealed BiPAP (Bilevel Positive Airway Pressure) QHS (every hour of sleep) and PRN (as needed) ...related to Chronic Obstructive Pulmonary Disease ..."<br><br>A record review of Resident #171's "Admission Record" revealed the facility admitted the resident on 05/29/24, with an original admission date of 01/05/24, and the resident had diagnoses including Chronic Obstructive Pulmonary Disease with Acute Exacerbation and Chronic Systolic (Congestive) Heart Failure.<br><br>On 08/20/24 at 9:36 AM, during an interview, Licensed Practical Nurse (LPN) #1 stated the facility's policy requires replacing all respiratory tubing weekly, and the tubing should be dated and stored in a dated plastic bag when not in use. She mentioned that she had never seen a bag for storing the tubing since she began working at the facility.<br><br>On 08/20/24 at 10:36 AM, during an interview, Assistant Director of Nursing (ADON) stated that nurses should review the oxygen tubing policy if unsure of the correct procedures. She confirmed that tubing is supposed to be changed weekly and turned off when not in use. She emphasized that the policy is in place to decrease the risk of potential or direct exposure to infectious diseases, air contaminants, and bacterial | F 695 | procedure of Respiratory care and review the plan. The Quality Assessment Performance Improvement team members will monitor the policies and procedures during monthly the meeting beginning September 18, 2024 for 3 months. The ADON and DON will monitor that two residents per week on Oxygen to ensure their tubing changed weekly and dated every Sunday night by nurses on 8/25/2024. Education on tubing changing and dating will be monitored and followed up every month for 3 months and continue on-going beginning September 18, 2024. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 695 | Continued From page 12<br>exposure. She stated that it is ultimately the responsibility of all nurses caring for residents on oxygen therapy.<br><br>On 08/20/24 at 11:20 AM, during an interview, the Director of Nursing (DON) stated that both she and the ADON educate nurses on the care of oxygen tubing. She mentioned that new employees receive a copy of the policy and procedures on changing oxygen tubing and keeping it in a bag when not in use. The DON confirmed that it is the cart nurse's responsibility to change, label, and care for oxygen/nebulization tubing, with the tubing usually being changed on the Sunday night/Monday morning shift. | F 695 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced | F 812 | | 9/19/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 812 | Continued From page 13<br>by:<br>Based on observation, interviews, and facility policy review, the facility failed to store food in accordance with professional standards for food service safety related to food items not dated, exposed foods, and expired foods in one (1) of two (2) kitchen observations.<br><br>Findings Include:<br><br>A review of the facility's policy titled "Labeling and Dating for Safe Storage of Food," revised 03/06/2020, revealed " ...All products should be dated when opened... Use Use-By dates on all food once opened... When food is taken out of an original container... write... the Use-By date..."<br><br>The facility did not provide a policy that specifically addressed exposed food products.<br><br>On 8/19/14 at 10:31 AM, an observation of the kitchen revealed Refrigerator #1, revealed the following: one (1) 46-ounce carton of orange juice with an "open on" date of 4/11/24 and a manufacturer's "best if used by" date of Feb 2024; one (1) opened gallon of 1 percent milk with a manufacturer's "best by" date of Aug 18 and a facility date of 7/30/24 with no indication of what the date meant; and one (1) five (5)-pound tub of pimento cheese spread with a facility "opened on" date of 7/8 and a manufacturer's "use by" date of 08/04/24. An observation of Refrigerator #2 revealed the following: four (4) unopened gallons of whole milk with a manufacturer's "best by" date of Aug 14; one (1) plastic storage bag of cheese slices with the date rubbed off, leaving the date illegible; one (1) container of leftover beef and gravy with a facility "use by" date of 8/16/24; and one (1) container of | F 812 | F 812<br>" The Dietary Supervisor acknowledged outdated food, opened food, and undated food immediately disposed of it on 8/19/2024. There were no negative outcomes.<br>" All residents that reside in the facility have the potential to be affected by the undated, exposed, and outdated foods.<br>" The Dietary Supervisor did an in-service all employees on 8/20/2024 on leftover storage, use by dates, labeling and dating for safe storage of food. The Dietary Supervisor and her staff will check foods/drinks daily for expiration dates. The focus will be to ensure products are dated and labeled. Expired products will be removed from the kitchen. Employees will be educated on the observation, education, and disposal of undated, opened, and outdated food.<br>" The Registered Dietitian will monitor the refrigerators as part of her weekly visits beginning 8/30/2024 for 12 weeks. The Quality Assurance Performance Improvement (QAPI) team met on 8/22/2024 to monitor the policy and procedures for the proper dating and storage of foods along with disposal of opened, not dated, and outdated foods within the policies and procedures outlined and will continue on a monthly meetly schedule. This will continue monthly along with observation of logs to ensure resident and food safety. The results of the monitoring will be taken to the QAPI Committee for review for 3 months beginning 9/18/2024. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 812 | Continued From page 14<br>leftover rice with a facility "use by" date of 8/18/24. An observation of the freezer revealed seven (7) four (4)-ounce cups of rainbow sherbet containing dairy that had been removed from the original box and had no date. An observation of the pantry revealed one (1) box of tea bags not individually wrapped, with the tea bags exposed. The dry bins revealed the lid on the sugar bin was not securely on the bin, leaving the sugar exposed.<br><br>On 08/19/24 at 10:31 AM, during an interview, the Dietary Supervisor (DS) acknowledged the outdated, exposed, and undated foods. The DS stated it was her responsibility to monitor the foods for expiration dates and quality. She reported that it was the responsibility of the staff who opened the food item to write an "opened on" date on the food package. The DS further explained that she in-serviced the staff on kitchen safety once a month.<br><br>On 08/22/24 at 12:52 PM, during an interview, the Administrator acknowledged he had been made aware of the expired, exposed, and undated food items that had been observed during the kitchen observation. The Administrator reported that his expectation was for the kitchen staff to regularly check the food, ensuring that foods are dated, labeled, and expired foods are removed from the kitchen. | F 812 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and | F 880 | | 9/19/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 15 | F 880 | | |

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 16<br>circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews and facility policy review the facility failed to prevent the potential for the spread of infection as evidenced by, facility staff observed transporting linen in an unsanitary manner for two (2) of six (6) hall observations.<br><br>Findings Include:<br><br>Review of the facility's policy titled, "Departmental (Environment Services) - Laundry and Linen", revised August 2009, revealed " ...The purpose of this procedure is to provide a process for the safe and aseptic handling, washing and storage of linen ... In Resident Rooms 1. Do not allow linen clean or soiled to touch clothing or uniform. 2. | F 880 | F 880<br>• The contaminated linen was returned to the laundry by the Certified Nurses Assistants (CNA's) that contaminated it to be washed, disinfected, and dried on 8/21/2024.<br>• All residents that reside at the facility have the potential to be affected.<br>• In-services were initiated by the Administrator, the Director of Nursing, and the Assistant Director of Nursing with all staff handling linen, infection control and policy and procedures for the proper handling of linen: nurses, CNA's, Dietary, Housekeeping. Infection Control, Proper Usage of Personal Protective Equipment | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 17<br>Handle all linen as though it is potentially infectious ..."<br><br>On 08/21/24 at 10:20 AM, an observation of Certified Nursing Assistant (CNA) #2 revealed the CNA hugging clean linen to her uniform going down the 400 hall and placing it on the laundry cart in the hallway. The laundry consisted of bed linen, towels and pads.<br><br>On 08/21/24 at 1:57 PM, in an interview with CNA #2, she stated she had 2 towels, 2 fitted sheets and 2 pads. She stated she was not paying attention to how she carried the laundry. She confirmed that her actions contaminated the laundry by carrying it against her uniform.<br><br>On 08/21/24 at 12:54, CNA #1 was observed carrying 2 towels wrapped up in her arms against her uniform down the 100 hall.<br><br>On 08/21/24 at 2:12 PM, in an interview with CNA #1 stated she was moving fast and was not thinking. She stated carrying the towels next to her uniform contaminated the towels. She stated she has been trained to carry the linen away from her uniform, she just forgot.<br><br>On 08/21/24 at 2:20 PM, in an interview the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) stated staff are supposed to transport clean and dirty laundry in a bag away from their uniform. She stated the uniform is considered dirty and by holding clean linen against their uniform, they contaminated the clean laundry, which could spread infection.<br><br>On 08/22/24 at 12:56 PM, in an interview, the Administrator stated he expects the CNAs to | F 880 | (PPE's) and Infection Control policies and procedures were used for education. All linen is to be transported by staff in plastic bags held far enough away from the employees' body to prevent contact.<br>• The Assistant Director of Nursing (ADON) and Director of Nursing (DON) will monitor the hallways along with other areas of the facility to ensure the proper handling of laundry to prevent further contamination. Monitoring began on 8/21/2024 of each hall will be monitored twice daily before and after lunch. This practice will continue for 12 weeks. Quality Assurance Performance Improvement met 8/22/2024 and will continue to meet monthly to review policies and procedures along with the review of in-services to ensure the proper handling of linen and to prevent any contamination of linen that could potentially harm residents. The QAPI team will meet for review on 9/18/2024 and continue for 3 months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255271 | A. BUILDING _____ B. WING _____ | C 08/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 18<br>follow policy when transporting linen. | F 880 | | |