STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255271	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and Complaint Investigation (CI), MS# 2670327, at the facility from 12/1/2025 through 12/4/2025. MS #2670327 was investigated regarding Resident Rights, Admission and Transfer, Abuse, and Quality of Care and F550 was cited. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656, F677, F679, F692, F761, F790, F812, F867 and F0880. The facility had a census of 73 and was licensed for 80 beds.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. 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. §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. §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 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F0550		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0550 SS = D	Continued from page 1 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. §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. §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. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure a resident's right to be free from invasion of personal privacy when the Administrator took and shared photographs of the resident without his consent for one (1) of 19 sampled residents. Resident #10 Findings Include: A review of facility's "Residents Rights and Qualify of Life Policy and Procedure", undated, revealed,"...All residents have the right to a dignified existence, self-determination and communication and access to people and services inside and outside the facility..." A record review of the "Admission Record" revealed the facility admitted Resident #10 on 10/12/25, with diagnoses including Quadriplegia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/25 revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 15, indicating he was cognitively intact. On 12/01/2025 at 2:05 PM, in an interview, Resident #10 stated that the Administrator followed him in her personal vehicle when he left the facility to get a haircut on November 5, 2025. He stated that the Administrator took pictures of him and sent them to his mother without his permission. The resident expressed that this upset him and violated his right to privacy. On 12/03/2025 at 9:59 AM, in a phone interview with Resident #10's mother, she stated she had not heard	F0550		

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F0550 SS = D	Continued from page 2 from her son that day (11/5/25) and had asked a friend at the facility to check on him. She reported that the Administrator called her shortly afterward and stated that the resident had gone to get a haircut. The Administrator then texted her pictures of Resident #10 taken at a red light, stating she was watching him from her car. The mother confirmed she did not ask for pictures and stated she felt it was inappropriate and a violation of his privacy. On 12/03/2025 at 10:36 AM, in an interview with the Administrator, she confirmed that Resident #10 frequently leaves the facility independently in his power chair. She stated that on the day in question, she was aware the resident's mother was concerned after not hearing from him. The Administrator reported she took it upon herself to drive and look for the resident. She admitted she took pictures of him from her car and texted them to his mother. She stated she was not thinking about privacy at the time but acknowledged that it could be viewed as a violation of resident rights. On 12/04/2025, in an interview with the Director of Nursing (DON), she stated she had heard the resident mention something about photos being taken but was unaware of details. She confirmed that photos should not be taken of residents without their consent and doing so would be an invasion of privacy.	F0550		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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,	F0656		

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F0656 SS = D	Continued from page 3 including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to implement care plan interventions related to oral hygiene (Resident #57) and Percutaneous Endoscopic Gastrostomy (PEG) care (Resident #70) for two (2) of 19 sampled residents. Findings Include: A review of the facility's "Care Plan Policy and Procedure," undated, revealed, "…Each resident's care plan will remain current and inform staff of resident's needs…" Resident #57 A record review of the "Admission Record" revealed the facility admitted Resident #57 on 2/14/25 with diagnoses including Need for Assistance with Personal Care.	F0656		

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F0656 SS = D	Continued from page 4 A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/25 revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated her cognition was severely impaired. A record review of the “Care Plan Report” revealed Resident #57 had a care plan “Focus” of “(Proper name of Resident) has an ADL self-care performance deficit…” with “Interventions/Tasks” including “Oral hygiene: setup/clean x’s (times) 1 person assist…” During an observation and interview on 12/1/25 at 2:29 PM, Resident #57 was lying in bed and reported she did not receive mouth care daily. She had visible discoloration and debris on her teeth. During an observation and interview on 12/3/25 at 3:23 PM, Resident #57 was in her room with her spouse present. Resident #57 explained that her teeth had not been brushed that day and her teeth had visible discoloration and she had a mouth odor. During an observation and interview on 12/3/25 at 3:50 PM, during an observation and subsequent interview, CNA #5 confirmed that Resident #57 had visible discoloration and debris on her teeth. She reported she brushed Resident #57’s teeth that day but acknowledged she should have provided oral care more than once and further explained that Resident #57’s teeth should be brushed after every meal. Resident #70 A record review of the “Admission Record” revealed the facility admitted Resident #70 on 2/11/25 with diagnoses including Dysphagia. A record review of the “Order Summary Report” revealed Resident #70 had a Physician’s Order, dated 2/11/25 to clean the Percutaneous Endoscopic Gastrostomy (PEG) site daily with warm soap and water. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/30/25 revealed Resident #70 required a staff assessment for mental status and that her cognitive skills for daily decision making was severely impaired. A record review of the “Care Plan Report” revealed Resident #70 had a care plan “Focus” of “(Proper Name of Resident) has PEG tube to upper mid abdomen…” with “Interventions/Tasks of “Clean peg site daily with warm	F0656		

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F0656 SS = D	Continued from page 5 soap and water cover with dry dressing every day…" During an observation of PEG tube care on 2/3/25 at 2:05 PM, Licensed Practical Nurse (LPN) #2 removed Resident #70's PEG tube dressing and cleaned only the external PEG tubing with soap and water. She dried the tubing with a dry gauze. The LPN did not clean the PEG tube insertion site. During an interview on 12/3/25 at 3:28 PM, LPN #2 she confirmed that not cleaning the PEG insertion site could cause residue to build up around the entry site and cause an infection. During an interview on 12/4/25 at 11:56 AM, LPN #3/Care Plan nurse explained that care plan interventions are to be used by staff to provide care as it focuses on patient care. During an interview on 12/04/2025 at 12:10 PM, the Director of Nursing (DON) stated she expected staff to provide care according to the resident's care plan.	F0656		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure Activities of Daily Living (ADL) care, including oral hygiene was provided for one (1) of one resident who required staff assistance with oral care, Resident #57. Findings include: A review of the facility's "ADL Care of A Resident Policy And Procedure," undated, revealed "…Resident ADL care will be provided to the resident according to the individualized resident needs..." A record review of the "Admission Record" revealed the facility admitted Resident #57 on 2/14/25 with diagnoses including Need for Assistance with Personal Care. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/25	F0677		

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F0677 SS = D	Continued from page 6 revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated her cognition was severely impaired. On 12/1/25 at 2:29 PM, during an observation and interview with Resident #57, the resident was lying in bed and reported she did not receive mouth care daily. She explained that when she requested oral care, staff told her they would return but did not do so. She reported her teeth were previously white and had become stained. An observation of Resident #57's mouth revealed visible discoloration and debris on the teeth. She reported the last time she received oral care was the prior Wednesday or Thursday. On 12/2/25 at 3:30 PM, during an observation of Resident #57 lying in bed, the resident reported she had been in bed most of the day and had not had mouth care that week. On 12/3/25 at 3:23 PM, during an observation and interview with Resident #57 at bedside with her spouse present, the resident reported her teeth had not been brushed that day. An observation revealed visible discoloration and mouth odor. On 12/3/25 at 3:45 PM, during an interview with Certified Nursing Assistant (CNA) #5, the CNA reported she was assigned to Resident #57 that day and had provided a bed bath and brushed the resident's teeth once. She explained Resident #57's teeth should be brushed after every meal. On 12/3/25 at 3:50 PM, during an observation and subsequent interview, CNA #5 confirmed that Resident #57 had visible discoloration and debris on the teeth. She reported she brushed Resident #57's teeth that day but acknowledged she should have provided oral care more than once. On 12/3/25 at 4:00 PM, during an interview with the Director of Nursing (DON), she explained that visible buildup on teeth develops over time and not within a few days. She reported her expectation was that Certified Nursing Assistants provide daily oral care, personal care, and hygiene according to individual resident needs.	F0677		
F0679 SS = E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities.	F0679		

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F0679 SS = E	Continued from page 7 §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide an ongoing program of individualized activities to meet the physical, mental, and psychosocial needs of residents residing on the Dementia Unit for two (2) of two (2) sampled residents reviewed on the Alzheimer's Unit (Residents #9 and #63), with the potential to affect all nineteen (19) residents on the unit. Findings include: A review of the facility's, "Life Connections Program," revised May 4, 2021, revealed, "Policy...Procedures. Life Connection Programs should be designed as an ongoing resident-centered activities program that incorporates the residents' interests... Life Connections activity may be scheduled seven (7) days a week... Specialized activities will be available for residents with cognitive impairment..." Resident #9 A record review of the "Admission record" revealed the facility admitted Resident #9 on 4/5/23 with diagnoses including Vascular Dementia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/30/25 revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated her cognition was moderately impaired. Resident #63 A record review of the "Admission record" revealed the facility admitted Resident #63 on 4/6/22 with diagnoses including Unspecified Dementia. A record review of the Quarterly MDS with an ARD of 9/18/25 revealed Resident #63 had a BIMS score of 3, which indicated her cognition was severely impaired.	F0679		

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F0679 SS = E	Continued from page 8 On 12/1/25 at 10:20 AM, during an observation of the Alzheimer's Unit dayroom, there were no activities in progress and many of the residents were sitting in the dayroom with the television on. On 12/3/25 at 12:07 PM, during an observation and interviews on the Alzheimer's Unit, the residents, including Residents #9 and #63, were seated in the dining hall eating lunch. No music or other sensory engagement was provided. Certified Nursing Assistant (CNA) #1 stated many residents had requested music during meals and that the unit's CD player had been removed some time ago. CNA #1 reported she had requested a replacement from administration, but none had been provided. Resident #9 stated music brought her peace when she was growing up and she desired it now more than ever. Resident #63 stated the residents needed music because it was soothing. On 12/3/25 at 12:46 PM, during an observation of the unit activity board and interview with Resident #9, there were two calendars posted, in which one was designated for daytime activities and one for evening activities. Neither calendar listed any times for when the activities would occur. The 12/3/25 "Day" calendar listed "This Day in History," and the 12/3/25 "Evening" calendar listed "Matching Cards," both without scheduled times. Resident #9 stated she did not know what "This Day in History" was and reported the only activity provided was watching television. She added that staff do not come to interact with them, nor do they perform the activities listed on the calendar. A record review of the Activity Calendar for December revealed a calendar for "Morning Activities" and "Evening Activities" with one activity listed per date and no specified time the activity was scheduled. On 12/3/25 at 12:48 PM, during an interview with CNA #1, she reported that no one comes to the unit to provide activities and that residents "wake, eat, watch television, and sleep. She explained that the residents need some type of additional engagement, something that stimulates them, and commented that just because they have dementia, that does not mean they would not enjoy activities. On 12/3/25 at 12:51 PM, during an interview with CNA #2, she reported that although an activity calendar is posted, no activities are provided and residents remain in the dayroom watching television. She confirmed that no one from the activities department had come to the unit that day.	F0679		

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F0679 SS = E	Continued from page 9 On 12/3/25 at 1:00 PM, during an interview with Registered Nurse (RN) #1, Dementia Unit Manager, she confirmed that activities were not being provided on the unit. On 12/4/25 at 10:36 AM, during an interview with the Activities Assistant Coordinator, he confirmed he was responsible for Dementia Unit activities and acknowledged that many scheduled activities had not been conducted. He stated he was often assigned to other duties that prevented him from completing activities. On 12/4/25 at approximately 10:41 AM, during an interview with the Director of Nursing (DON), she stated she had identified that activities were not consistently provided on the Dementia Unit and had instructed the Activities Assistant Coordinator to conduct activities daily. On 12/4/25 at 10:57 AM, during an interview with the Administrator, she reported she was not aware that activities were not being conducted. She stated it was regulatory for residents to have activities “every hour on the hour.” She stated music was important to creating a pleasant environment and residents should have music when desired.	F0679		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F0692		

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F0692 SS = D	Continued from page 10 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide care and services in a manner to prevent complications for one (1) of three (3) residents reviewed for tube feeding and nutrition, Resident #70. Findings include: A review of the facility's "Enteral Feeding Tube – Care of Procedure," undated, revealed, "…Purpose: to prevent irritation and skin breakdown around feeding tube…Procedure…4. Clean skin around tube with warm water and soap or wound cleaner…" A record review of the "Admission Record" revealed the facility admitted Resident #70 on 2/11/25 with diagnoses including Dysphagia. A record review of the "Order Summary Report" revealed Resident #70 had a Physician's Order, dated 2/11/25 to clean the Percutaneous Endoscopic Gastrostomy (PEG) site daily with warm soap and water. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/30/25 revealed Resident #70 required a staff assessment for mental status and that her cognitive skills for daily decision making was severely impaired. On 12/3/25 at 2:05 PM, during an observation of PEG tube care performed by Licensed Practical Nurse (LPN) #2 for Resident #70, the LPN removed the PEG tube dressing and cleaned only the external PEG tubing by wiping from bottom to top on each side using gauze saturated with soap and water. She dried the tubing with a dry gauze. The LPN did not clean the PEG tube insertion site. On 12/3/25 at 3:28 PM, during an interview with LPN #2, she confirmed that not cleaning the PEG insertion site could cause residue to build up around the entry site and cause an infection. On 12/3/25 at 4:10 PM, during an interview with the Director of Nursing (DON), she stated the purpose of cleaning the PEG site correctly was to prevent infection. She reported the manner in which LPN #2 performed PEG care could cause infection and presented	F0692		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0692 SS = D	Continued from page 11 a cross-contamination issue.	F0692		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications and biologicals were securely stored and properly labeled when a controlled substance returned by a resident was left unlabeled on a medication cart and when a wound care cart containing treatment chemicals was unlocked and accessible to residents for two (2) of three (3) medication/treatment carts reviewed. Findings Include: A review of the facility's "Medication Storage Policy and Procedure," undated, revealed, "…Policy: 1. Medications and biologicals will be maintained in a secured location only accessible to designated staff…"	F0761		

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F0761 SS = D	Continued from page 12 On 12/2/25 at 1:33 PM, during an observation of a medication cart with Licensed Practical Nurse (LPN) #1, a loose pill was noted in a clear plastic sleeve labeled “12 PM” but without the resident’s name, drug name, strength, dosage, or any identifying information. LPN #1 identified the pill as Oxycodone-Acetaminophen Tablet 5-325 milligrams (mg) that Resident #10 had checked out when leaving the facility on pass and returned that morning. The pill had been placed on the cart without a label and without secure storage. On 12/2/25 at 1:35 PM, during an interview with LPN #1, she reported she placed the medication on the cart after the resident returned it and planned to notify the night nurse during shift report. When asked how other nurses would know what the medication was, she acknowledged they would not and confirmed that the medication could be administered in error or diverted since it was unlabeled and unsecured. She stated she should have asked the Director of Nursing (DON) how to handle the medication upon return. On 12/3/25 at 2:18 PM, during an observation and interview with LPN #2, the wound care cart on the 400 hall was observed. Although the cart appeared locked, with the lock pushed inward, all drawers opened freely. The cart contained wound treatment supplies including triple antibiotic ointment, calamine lotion, MediHoney, and Nystatin powder. LPN #2 confirmed she believed the cart was locked but realized it was fully accessible and acknowledged that residents, including cognitively impaired residents, could access the unsecured chemicals. On 12/4/25 at 9:27 AM, during an interview with the DON, she stated the returned Oxycodone 5 mg tablet for Resident #10 should have been destroyed by two nurses per facility policy and should not have been left on the medication cart. She explained the risks included medication error or diversion since the pill was unlabeled and unaccounted for. Regarding the wound care cart, the DON stated the cart had been unable to lock since September 2025 and should not have been stored on the hallway. She explained the interim process was for staff to pull treatments from the cart and store supplies in the medication room. The DON confirmed residents could ingest wound chemicals if the cart remained unlocked and acknowledged that wandering residents lived on the unit. The DON provided documentation showing the facility received a quote for a new cart on 9/12/25 and ordered a replacement on 11/18/25.	F0761		

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F0761 SS = D	Continued from page 13 A record review of the "Admission Record" revealed the facility admitted Resident #10 on 10/12/25, with diagnoses including Quadriplegia. A record review of the “Order Summary Report” revealed Resident #10 had a Physician’s Order, dated 10/10/24 for Oxycodone-Acetaminophen Tablet 5-325 milligrams.	F0761		
F0790 SS = D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(f) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days,	F0790		

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F0790 SS = D	Continued from page 14 the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident received a diet and follow-up dental care consistent with the resident's nutritional needs and edentulous status when the resident remained without dentures for over two (2) months and continued to receive regular-texture meals for one (1) of nineteen (19) sampled residents (Resident #76). Findings Include: On 12/01/2025 at 1:50 PM, in an interview, Resident #76 stated his teeth had been lost in the laundry. The facility had taken him to a dentist about a month ago for a fitting, but he had not heard anything further about replacement dentures. On 12/03/2025 at 12:35 PM, an interview and observation of Resident #76 revealed he had a lunch tray consisting of fried chicken, green beans, mashed potatoes, and cornbread. He reported difficulty chewing the meat without his teeth and stated that meals often included pork chops or other tough meats. He expressed that it was hard for him to cut and swallow food without dentures. The tray was identified as a regular diet with no accommodation for edentulism. On 12/04/2025 at 10:30 AM, in an interview with Resident #76's Certified Nurse Aide (CNA) #6, she stated that the resident feeds himself but frequently complains that meat on his tray is hard to chew. She confirmed he is receiving a regular diet and stated that he could probably benefit from an easier diet for people with no teeth. She further reported that she was aware he had an appointment for dentures a few months ago. On 12/04/2025 at 10:50 AM, in a phone interview with the receptionist at the dental office, she confirmed Resident #76 was seen on 09/11/2025 for an initial evaluation and limited x-ray, but was not fitted for dentures at that time. She stated there had been no follow-up from the facility, and as of 12/04/2025, he had not returned. She explained that the full denture process typically takes approximately two months and that the resident could have had his dentures by mid-November if the process had continued	F0790		

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F0790 SS = D	Continued from page 15 appropriately. On 12/04/2025 at 12:14 PM, in an interview with the Director of Nursing (DON), she confirmed that she was unaware the resident had not returned for a follow-up visit since the initial appointment in September. She explained that the transportation CNA is responsible for notifying the DON or nursing team after appointments and making arrangements for any required follow-up. She confirmed this did not occur for Resident #76. On 12/04/2025 at 2:07 PM, in an interview with the Administrator, she confirmed that the resident had not returned to the dental provider and that she personally contacted the office on 12/04/2025 to schedule a follow-up once she became aware. She stated the resident now has a same-day appointment. A record review of the “Admission Record” revealed the facility initially admitted Resident #76 on 9/18/24 with diagnoses including Type 2 Diabetes Mellitus. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/10/2025 indicated Resident #76 had a Brief Interview for Mental Status (BIMS) score of 9, reflecting moderate cognitive impairment. A record review of the “Order Summary Report” revealed Resident #76 had a Physician’s Order, dated 9/18/24, for a Regular diet, Regular texture, Regular consistency.	F0790		
F0812 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	F0812		

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F0812 SS = F	Continued from page 16 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, interview, and facility policy review, the facility failed to ensure food items were stored, dated, and maintained in accordance with professional food safety standards for one (1) of three (3) kitchen observations. Findings include: A review of the facility's "Food Storage Areas Policy and Procedures," undated, revealed, "…Dry storage areas will be kept in a condition which protects foods from infestation. Procedure: 1. All items must be stored at least 6 inches off the floor...Care of the Storeroom 1. The staff will maintain care of the storeroom according to the following directions…b. New stock is placed in back of previously delivered items so that older stock will be issued first. C. Refrigerated and frozen foods are dated upon delivery. Foods with expiration dates are used prior to date on the package…" On 12/1/25 at 10:30 AM, during an observation of the kitchen with the Dietary Manager (DM), the dry storage room contained two (2) dry storage bins holding rice and sugar that were not dated. A twenty-five (25) pound bag of Domino sugar and a twelve (12) pound bag of Ellington coffee were stored directly on the floor. A sugar-free no-bake cheesecake mix and a box of powdered sugar were observed opened and stored in clear Ziploc bags without labels or dates. Nine (9) Del Monte bananas stored in a box were black with dark brown spots; one banana was split open, black, and mushy. In the refrigerator, fifty (50) single-serve Hiland chocolate milk cartons were dated 10/27/25, and twenty (20) cartons were dated 11/20/25. Seventy-six (76) single-serve Daily sour cream packs stored in two brown boxes were dated 3/5/25. On 12/1/25 at 10:55 AM, during an interview with the DM, she acknowledged the expired chocolate milk and sour cream should have been discarded on the expiration date. She explained that serving expired dairy products could result in residents developing gastrointestinal	F0812		

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F0812 SS = F	Continued from page 17 illness. She reported she was responsible for checking behind dietary staff. She confirmed that no food items should be stored on the floor, that all refrigerated items should be labeled and dated, that the bananas should have been discarded, and that dry storage bins were required to be dated. She explained the purpose of dating and labeling food items was to prevent spoiled food from being served to residents. On 12/4/25 at 1:25 PM, during an interview, the Nursing Home Administrator (NHA) explained she expected the Dietary Department to follow facility policy and regulatory requirements to ensure resident safety. The NHA reported she expected dietary staff to rotate stock daily and remove all expired food items from the kitchen.	F0812		
F0867 SS = E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.	F0867		

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F0867 SS = E	Continued from page 18 §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.	F0867		

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F0867 SS = E	Continued from page 19 §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent recurrence of a previously cited deficiency, specifically, the facility was cited for failing to store food in accordance with professional standards for food service safety related to food items not dated, exposed foods, and expired foods during an annual recertification survey on 8/22/24 and was cited again for the same deficiency during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of ten (10) deficiencies cited. F812 Findings include:	F0867		

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F0867 SS = E	Continued from page 20 A review of the facility's, "QAPI Plan," undated, revealed, "...Aspects of service and care are measured against established performance goals. Key performance indicators are measured and trended on a quarterly basis. The QAPI Committee analyzes performance to identify and follow-up on areas of opportunity. The facility will utilize the best available evidence…to define and measure goals. The facility continually identifies opportunities for improvement and reviews the following areas to prioritize opportunities..." Record review of the "Provider History Report" revealed the facility received a citation for F812 – Food Procurement, Store/Prepare/Serve-Sanitary with a "Plan/Date of Correction" of 10/18/2024. Record review of the CMS-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date 8/22/24, revealed the facility received a citation for F812, "…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…" During the current recertification survey, the facility failed to ensure food items were stored, dated, and maintained in accordance with professional food safety standards for one (1) of three (3) kitchen observations. On 12/4/25 at 10:57 AM, during an interview with the Administrator, she stated she was unsure why the dietary department was cited again. During her meetings with the Dietary Manager, she indicated that everything was labeled and dated, and there were no expired foods on the shelves.	F0867		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F0880		

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F0880 SS = D	Continued from page 21 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 circumstances. (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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F0880		

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F0880 SS = D	Continued from page 22 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to implement appropriate infection prevention and control practices during indwelling catheter care (Resident #6), and failed to follow hand hygiene, glove-use, surface sanitation, and Enhanced Barrier Precautions (EBP) requirements during enteral feeding tube care (Resident #70) for two (2) of three (3) residents reviewed for care. Findings include: A review of the facility's "Hand Hygiene Policy and Procedure," dated 4/11/23, revealed, "…Hand hygiene will be performed by all staff consistent with accepted standards of practice, to reduce the spread of infection and prevent cross contamination…" A review of the facility's "Isolation Policy and Procedure," undated, revealed, "…Enhanced Barrier Precautions (EBP): 1. EBP Precautions are utilized for residents that have wounds and/or indwelling medical devices (Central line Catheter, feeding tube…)…2. PPE (Gloves and gown prior to the high-contact care activity) is to be utilized…during high-contact resident care activities…g. Device care or use (Central line, urinary catheter, feeding tube…)." Resident #6 On 12/2/25 at 1:50 PM, during an observation of catheter care performed by Certified Nursing Assistant (CNA) #3 for Resident #6, CNA #3 washed the soiled catheter tubing, rinsed it, and patted it dry while continuously wearing the same gloves. She then touched the resident's shoulder and thigh to reposition him without removing gloves or performing hand hygiene. On 12/2/25 at 1:55 PM, during an observation of	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255271	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

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

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F0880 SS = D	Continued from page 23 perineal care provided by CNA #4 for Resident #6, CNA #4 removed a soiled brief after a bowel movement while wearing gloves and then used the bed remote with the same soiled gloves, contaminating environmental surfaces. On 12/2/25 at 1:56 PM, during an interview with CNA #4, she confirmed she should have removed soiled gloves and performed hand hygiene prior to touching environmental surfaces. She acknowledged the risk of spreading infections. On 12/2/25 at 2:01 PM, during an interview with CNA #3, she confirmed she should have removed gloves, performed hand hygiene, and reapplied clean gloves prior to repositioning Resident #6. She acknowledged the potential for the spread of infection from the catheter area. On 12/4/25 at 9:30 AM, during an interview with the Director of Nursing (DON), she stated her expectation was that staff change gloves and perform hand hygiene after each care task. The DON reported that CNA #3 could have spread infection from the catheter area and CNA #4 could have spread infection from fecal matter to surfaces in the resident's room. A record review of the "Admission Record" revealed the facility admitted Resident #6 on 1/13/25 with diagnoses including Chronic Obstructive Pulmonary Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/16/25 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. A record review of "Orders" tab in the electronic medical record, revealed Resident #6 had a Physician's Order, dated 11/25/25 for catheter care. Resident #70 On 12/3/25 at 2:15 PM, during an observation of Percutaneous Endoscopy Gastrostomy (PEG) tube care performed by Licensed Practical Nurse (LPN) #2 for Resident #70, LPN #2 donned a gown and gloves at the entrance and performed hand hygiene before applying gloves. She then opened the clean supply cart multiple times and used the computer mouse while wearing gloves. She entered the room, placed supplies directly on the bedside table without sanitizing the surface or using a barrier, and pressed buttons on the feeding pump while wearing gloves. She removed the PEG dressing while	F0880		

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F0880 SS = D	Continued from page 24 still wearing the same gloves. She cleaned only the PEG tubing, not the insertion site. She removed gloves and reapplied clean gloves without performing hand hygiene. She dried the tubing with gauze, then again removed gloves, performed hand hygiene, and reapplied gloves. She removed a syringe from a storage bag and attempted to flush 150 cubic centimeters (cc) of water; when the water did not move, she used the plunger, met resistance, and exited the room to obtain a stethoscope. She removed her gown, gloves, and supplies upon exit. On 12/3/25 at 2:45 PM, during an observation of LPN #2 returning to Resident #70's room, she applied gloves without performing hand hygiene and not donning a gown before flushing the tube. She gathered supplies and exited the room without performing hand hygiene. On 12/3/25 at 3:28 PM, during an interview with LPN #2, she confirmed she did not sanitize the bedside table or place a barrier before placing supplies. She confirmed she touched the cart, computer mouse, and feeding pump with gloved hands. She stated she should have removed gloves and washed her hands before beginning PEG care and before re-gloving. She confirmed she removed the PEG dressing with contaminated gloves. She reported she did not perform hand hygiene frequently enough and stated the purpose of Enhanced Barrier Precautions was to protect residents from organisms present on staff clothing. On 12/3/25 at 4:10 PM, during an interview with the DON, she stated LPN #2 should have washed her hands before and after care and upon room entry. She stated the PEG site must be cleaned correctly to prevent infection. She stated a barrier should have been used before placing supplies on the bedside table. She stated Enhanced Barrier Precautions were expected during PEG tube care to protect residents from infection. She reported that the manner in which LPN #2 performed care presented a cross-contamination risk. A record review of the "Admission Record" revealed the facility admitted Resident #70 on 2/11/25 with diagnoses including Dysphagia. A record review of the "Order Summary Report" revealed Resident #70 had a Physician's Order, dated 2/11/25 to clean the Percutaneous Endoscopic Gastrostomy (PEG) site daily with warm soap and water. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/30/25 revealed Resident #70 required a staff assessment for	F0880		

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F0880 SS = D	Continued from page 25 mental status and that her cognitive skills for daily decision making was severely impaired. A record review of the Enhanced Barrier Precautions signage posted on Resident #70's door revealed staff were to wear gown and gloves for high-contact care activities, including feeding tube care.	F0880		