MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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

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{M 000}	Continued From page 1 planned for the use of a lift resulting in the resident sustaining a fracture of the tibia. The facility also failed to report this event. The regulatory requirements that constitute the Immediate Jeopardy were as follows: M075 Governing Body M225 Sufficient Nursing Staff M350 Administration M500 Resident Rights M615 Pressure Ulcers M630 Behavioral Health Services M745 Pharmacy Services M735 Resident Records The facility's Administrator was notified of the Immediate Jeopardy and SQC on 05/21/21. Due to the magnitude of the systemic regulatory noncompliance with Medicare and Medicaid participation requirements, the State Agency determined the facility was unable to provide evidence of systemic corrections to remove the Immediate Jeopardy (IJ) prior to exit from the facility and therefore, the Immediate Jeopardy is considered ongoing.	{M 000}		
{M 075}	45.2.10 Governing Authority Governing Authority. The term "governing authority" shall mean owner(s), Board of Governors, Board of Trustees, or any other comparable body duly organized and constituted for the purpose of owning, acquiring, constructing, equipping, operating and/or maintaining a facility, and exercising control over	{M 075}		7/14/21

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{M 075}	Continued From page 2 the internal affairs of said facility. This Statute is not met as evidenced by: Based on an interview the governing body failed to act on information reported by the facility's management regarding operation of the facility. The governing body failed to provide oversight for the facility's Quality Assurance Performance Improvement (QAPI) program and related facility concerns. The governing body failed to hold the Administrator accountable for the safe daily operations of the facility. This had the potential to affect 65 of 65 residents in the facility. The facility's failure to act on reported information by the facility's management regarding operation of the facility and failure to be accountable, engaged, and involved for the implementation of facility policies and management of the facility, put all residents residing in the facility at risk for serious harm, serious injury, serious impairment, or possible death. This failure resulted in worsening pressure ulcers, missed significant medications, abuse and failure to provide sufficient and competent staff, failure to provide behavioral health services and competent staff for behavioral health needs, and failed to have an effective QAPI program. The situation was determined to be an Immediate Jeopardy (IJ) which began on 11/17/2020 after the SA entered the facility and identified the failure of the facility's governing body to act on reported information by the facility's management regarding operation of the facility to decrease the likelihood of serious injury, harm, impairment, or death. The IJ existed at M0075 Governing Authority.	{M 075}	1. During the 5/24/21 Quality Assurance Performance Improvement Committee Meeting, the Senior Director of Clinical Services and Owner/Managing Member educated the QAPI Committee on the QAPI Committee process and the revised agenda. The Senior Director of Clinical Services and Owner/Management Member also introduced the necessary audits with corresponding calendars and revised trending tools. QAPI Committee members included the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing/Infection Control Coordinator, Dietary Manager, Business Office Manager/Human Resources, Life Connections, Housekeeping Supervisor, Admissions Coordinator, Minimum Data Set Coordinator, Rehabilitation Director, Lead Certified Nursing Assistant, Maintenance Supervisor, and Medical Records. The Owner and Senior Director of Clinical Services, as members of the Governing Body, provided education to the QAPI Committee regarding the need to participate regularly in QAPI process, need to identify Root Causes. The Governing Body and the Facility Management team changed the Medical Director of the Facility. The new Medical Director officially accepted the role and responsibilities of the Medical Director as of 5/26/2021 and began work on 5/26/2021. The Owner provided education to the new Medical Director on the responsibilities and status of the Facility	

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{M 075}	Continued From page 3 The IJ was not removed prior to the State Agency (SA) exit on 5/26/2021 and was considered ongoing. The facility provided a Credible Removal Plan, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interviews and in-service sign-in sheets review. The facility provided evidence the facility had implemented corrective actions listed in the Credible Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ has been lowered from the severity of a Level IV to the severity of a Level II. The facility will remain out of compliance at the Severity of Level II that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: On 5/20/21 at 10:00 AM, an interview with the Regional Director of Operations (RDO) revealed the owner of the facility would be considered the Governing Body. The RDO stated the facility does not have a policy that addresses the Governing Body.	{M 075}	on 5/25/2021. 2. All residents have the potential to be affected by the deficit practice cited. 3. Beginning 6/01/21 the Administrator presents the QAPI meeting minutes and reports to the Governing Body monthly for review. The Governing Body will evaluate and provide feedback to Administrator. On 6/03/21 a conference call was held among the Owner, Director of Operations, and Director of Clinical Services to review the following: 1) the outcomes of the survey; 2) expectations and roles of the Governing Body as outlined in the Rules and Regulations; and 3) the development of a plan for the following communication/monitoring tools: caring for pressure wounds, ensuring effective pharmacy services and reducing medication issues, dealing with abuse and neglect effectively, ensuring sufficient and competent staff, providing behavioral health services, and providing a functioning QAPI Committee. The Owner requested the assistance of the Corporate Team and the Independent Consultant to conduct root cause analyses of these failures and to deliver a Corrective Action plan for improvement for the Governing Body□s oversight. 4. QAPI meetings have been scheduled on the facility calendar every other week monthly beginning 7/2/21 times two months. A schedule was created to bring audit findings to QAPI meetings. Findings will be brought to QAPI monthly for review, revision, or resolution of the plan. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance. The	

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{M 075}	Continued From page 4 On 05/20/21 at 2:00 PM, an interview with the Administrator revealed the owner is the governing body. The Administrator stated that he reports to the Regional Corporate Operations Manager. The Administrator stated the facility's policies are developed by the corporate department. The Administrator stated it is his responsibility to make sure the policies are followed. On 5/20/21 at 2:30 PM, an interview with the owner confirmed he is the governing body. The owner stated he appoints the Administrator, and that the Administrator reports directly to him. The owner stated he is a part of the Quality Assurance Performance Improvement (QAPI) program and that any QAPI issues are brought to him through emails, phone calls or fax by the Administrator. He stated he does not have a particular process to receive the QAPI information. The owner stated the pharmacy was changed during the summer last year. The owner stated he was aware of the issues with the medications, staffing, residents being admitted with behaviors and wound issues. He stated he did not know how severe it was and that all this was an eye opener to him. The owner confirmed his QAPI program failed but he did not know where the failure began and with whom. Removal Plan: On 5/24/2021 during the QAPI Committee Meetings, the Senior Director of Clinical Services and Owner/Managing Member educated the QAPI Committee on the QAPI Committee process and the revised agenda. The Senior Director of Clinical Services and Owner/Management Member also introduced the necessary audits with corresponding calendars and revised trending tools. QAPI Committee	{M 075}	Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

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{M 075}	Continued From page 5	{M 075}		

members included the Administrator, DON, Medical Director, ADON/ICC, Dietary Manager, BOM/HR, Life Connections, Housekeeping Supervisor, Admissions Coordinator, MDS Coordinator, Rehabilitation Director, Lead Certified Nursing Assistant, Maintenance Supervisor, and Medical Records.
The Owner and Senior Director of Clinical Services, as members of the Governing Body, provided education on 5/24/21 to the QAPI Committee regarding the need to participate regularly in QAPI process, need to identify Root Causes.
The Governing Body and the Facility Management team changed the Medical Director of the Facility. The new Medical Director officially accepted the role and responsibilities of the Medical Director as of 5/26/2021 and began work on
5/26/2021. The Owner provided education to the new Medical Director on the responsibilities and status of the Facility on 5/25/2021.
Validation:
The SA validated through Department Head interviews and reviews of the Quality Assurance and Performance Improvement (QAPI) sign in sheets, the facility held a QAPI meeting on 5/24/21. Interviews with department heads verified the QAPI meeting was held, and the committee received education on the QAPI process and revised agenda. The Senior Director of Clinical Services verified she introduced possible auditing processes, calendars, and trending tools that can be utilized for the QAPI process.
The SA validated through in-service sign in sheets and an interview with the Senior Director of Clinical Services, the Owner and the Senior Director of Clinical Services provided education to the QAPI committee regarding the need to

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{M 075}	Continued From page 6 participate regularly in the QAPI process and the need to identify root cause analysis of issues identified at QAPI meetings. The SA validated through interview and record review, the Owner provided education on the responsibilities of the Medical Director and status of the facility regarding survey findings to the new Medical Director on 5/25/21. The SA validated through interview and contract review, the new Medical Director signed a contract and officially accepted the role and responsibilities of the Medical Director on 5/26/21.	{M 075}		
{M 225}	45.4.1 Nursing Facility Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements: 1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio. 2. Each facility shall have the following licensed personnel as a minimum: a. Seven (7) day coverage on the day shift by a registered nurse. b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day shift and be responsible for all nursing services in	{M 225}		7/14/21

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{M 225}	Continued From page 7 the facility. c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse. d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse. e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse. f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse. 3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. 4. There shall be at least two (2) employees in the facility at all times in the event of an emergency. This Statute is not met as evidenced by: Based on observations, resident interviews, staff interviews, and record review, the facility failed to have sufficient nursing staff to meet the needs of the facility residents as evidenced by failure to protect residents from abuse (Residents #1, #6,	{M 225}	1. Effective 5/14/21, the Facility Management, with the assistance of Corporate Staff, has actively been recruiting nurses and nurse aides. Over the past several years, the Facility	

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{M 225}	Continued From page 8 #9), worsening pressure ulcers (Residents #3, #5, #12, #17), failure to administer medications timely (Residents #1, #5, #8, #10, #11, #12,#15 and #17), delay in incontinent care (Resident #8), failure to use lift for transfer Residents #2, #14), for 13 of 24 sampled residents out of a total of 65 residents in the building. The failure to have sufficient nursing staff placed residents in the facility at risk for serious harm, injury, impairment or death. The situation was determined to be an Immediate Jeopardy (IJ) on 05/21/2021 and was determined to exist on 3/17/2021 when a resident with known aggressive behaviors was admitted to the facility without an increase in staffing to ensure other residents were not physically and verbally abused. The IJ and Substandard Quality of Care (SQC) existed at M225 Nursing Facility. The IJ was not removed prior to exit on 05/26/2021 and was considered ongoing. The facility provided a Credible Removal Plan of IJ, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit in order to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interviews, record reviews, and in-service reviews. The facility provided evidence the facility had implemented corrective actions listed in the Credible Allegation of Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ has been lowered from the severity of a Level IV to the severity of a Level II. The facility will remain out of compliance at the	{M 225}	continues to employ agency staff as needed to keep staffing numbers within acceptable parameters. The Assistant Director of Nursing(ADON) reviewed the schedule on 5/21/21 and again on 5/24/21 and called in additional staff. On 5/24/21, the Corporate Owner approved for additional Facility staff/agency staff to bring staffing numbers up to acceptable levels and to provide resident care. Staffing in the general facility care area was increased that day on 5/24/21. Staffing was reviewed with the Facility management team, the Owner, and the Senior Director of Clinical Operations on 5/26/21. It was determined that the Facility had calculated its staffing ratio as one unit instead of two distinct units. Staffing in the general Facility care area was increased to meet state and federal staffing requirements. Effective 6/05/21, the Transportation Aide resumed assisting the ADON in creating the Certified Nurses Aides schedule. 2. All residents have the potential to be affected by the deficit practice cited. 3. Beginning 6/5/21 the schedule was completed two weeks in advance and was reviewed by the Administrator or Director of Nursing (DON) to ensure the schedule has adequate coverage. Daily, actual staffing is monitored by the ADON and/or Transportation/Lead CNA by reviewing the schedule and agency staff sign in sheet and verifying actual staff in the building. Effective 05/24/21 the ADON and/or Transportation/Lead CNA will be notified by facility staff if there is staff that fail to report for their assigned shift. When call-ins do occur, the ADON and /or	

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{M 225}	Continued From page 9 Severity of Level II that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Record review of the facility's, "Staffing" policy, dated 6/1/00, noted it is the policy of the facility to provide adequate staffing to meet the needs of the resident population. On 05/04/2021 at 1:14 PM, the State Agency (SA) observed Resident #1 pacing up and down the facility's hallway screaming and cursing loudly with his fist balled up and going in and out of other resident's room unsupervised. At the time of this observation, the facility had two (2) Licensed Practical Nurses (LPN) and six (6) Certified Nurse Aids (CNAs) working the Long-Term Care Unit where the resident lived. In a separate secured area of the facility, there was (1) LPN and 2 CNAs working the Alzheimers Dementia (AD) Unit. A review of the posted staffing sheet was consistent with staffing observed. On 05/06/21 at 10:45 AM in an interview with Certified Nursing Assistant (CNA) #7, revealed he had been a CNA at the facility for two years. CNA #7 explained that he has had to work overtime frequently lately due to needing staff. He explained he usually works 7-3 shift but has also work 7 AM to 11 PM shifts when needed. On 05/06/21 at 3:30 PM, an interview with CNA #12, revealed she was working a 12-hour shift today instead of the usual 8 hour shift scheduled. She further explained there is always problems with enough staffing and the CNAs work short. She explained working short is hard on residents	{M 225}	Transportation/Lead CNA will attempt to call in other staff to cover the shift as well as attempt to contact the staffing agency for assistance. If those attempts fail, one of the two will cover the shift as appropriate determined by the position that called in until relieved. If two nurses fail to report for duty on the same shift, then the ADON will call the DON for assistance. On 5/24/21, the Senior Director of Clinical Operations provided one on one education to ADON and Transportation Aide to include staffing based on acuity and layout, staffing patterns, and shifts. The ADON and the Transportation Aide were educated on nurse staffing and creating a stable staffing pattern for implementation. 4. Medical Records or Director of Nursing will audit staffing sheets daily times four weeks beginning 6/29/21 then monthly beginning 7/29/21 times three months. Findings will be brought to QAPI monthly beginning 7/2/21 for review, revision, or resolution of the plan for six months. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance. The Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

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{M 225}	Continued From page 10	{M 225}		

and the staff.
On 05/05/2021 at 10:00 AM in an interview with Resident #8, she explained she must wait for long periods of time for CNAs to answer call lights, approximately 30 minutes.
On 05/10/21 at 3:15 PM in an interview with Resident #12, revealed he uses a urinal but needs to have a brief changed occasionally due to bowel incontinence. He explained he must wait long periods of times to have the call light answered and cleaned up.
On 05/11/2021 at 12:00 PM in an interview with Resident #15, the resident explained sometimes it takes up to three (3) hours to get pain medications after he request medications and up to 30 minutes or longer to have a new brief changed . He reported he knows other residents are in need to, but he knows he needs to be taken care of and is tired of fighting with the facility.
On 05/11/21 at 4:45 PM in an interview with LPN #14 revealed on 05/09/21 on the 3-11 shift, it was just her and a CNA until after dinner. The nurse said she had to choose between giving medications and changing the resident's briefs.
On 05/12/21 at 10:00 AM in an interview with CNA #9, revealed she has been a CNA for 14 years and all this time has been at the current facility. She reported that she works the Dementia Unit 12 hours a day and usually there are 2 CNA working the unit but lately has only had one. She explained most of the time she works by herself with 14-16 Dementia residents since February 2020. She reported a nurse is always on the unit and sometimes it is a Registered Nurse (RN) but usually a Licensed Practical Nurse (LPN). She reported the nurse has never helped with resident care, but sometimes will help pass out a tray. She reported that as of right now there is one resident with total care and cannot walk but the other

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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) COMPLETE DATE
{M 225}	Continued From page 11	{M 225}		

residents walk. She stated that in the past, the Alzheimers Dementia (AD) Unit has had up to 5 residents for total care and 4 residents in a wheelchair. She explained Resident #20 requires a sit to stand lift daily. She further explained another resident, Resident #30 requires assist with a sit to stand frequently due to resident is inconsistent with standing on her own. She reported she has used the sit to stand lift by herself due to not having enough staff on the unit. She reported that she has reported short staffing to Director of Nursing (DON) and Assistant Director of Nursing (ADON) but nothing has been done about the staffing. She explained when using a sit to stand lift alone, a resident could be dropped, and reports she is not able to care for residents as needed due to short staffing. She stated also she felt that there has been a couple of falls on the Dementia Unit due to low staffing. She stated a resident's light was going off for at least 10 minutes, but she was assisting another resident with a shower and by the time she went to answer the light resident was on the floor, she reported another resident fell in the TV room while she was assisting another resident. She explained if there would be 2 CNAs on the unit one CNA could answer call lights while the other CNA is providing showers. She explained she has not been able to follow care plans due to not having enough staff and this could be a hazard to all residents on the unit.

Interview on 5/13/21 at 12:32 PM with CNA # 9 said she has had to work the AD unit without another CNA more than one occasion and has had to transfer residents via sit to stand and full body lifts without assistance due to the nurse cannot assist because she could not leave the residents with behaviors. The CNA said on one occasion she was in the room with a nurse transferring a resident via Hoyer and one of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 225}	Continued From page 12	{M 225}		

behavior residents started acting out and they had to run out in the hall to stop the resident from hitting another resident. She stated that using a stand with one (1) person instead of two (2) could get residents hurt and maybe even dropped from a lift.
Interview on 5/13/21 at 12:32 PM with CNA #8 confirmed she has been on the Alzheimer's unit without another CNA more than once and voices concerns for the residents and herself. She explained that it is hard to watch the elders with behaviors and to provide care for other residents. The CNA said she had to transfer residents via Hoyer lift without assistance because the nurse had to monitor the other residents with behaviors. The CNA said she was in-serviced about the care plans and know the staff should follow the plan of care but some of the residents cannot transfer themselves according to the care plans. The staff must do whatever it takes to transfer the resident.
On 5/20/21 at 09:15 AM, the DON revealed she has never read the Federal regulations for nursing homes and is not aware of what each regulation means. The DON revealed because of the facility's budget, her hands were tied regarding staff, and she was not allowed to bring in contract workers anymore. She explained the facility did use agency staffing in December after being cited for staffing concerns, but not since then. The DON reported the facility had 4 residents on the Alzheimer's unit that could not transfer independently. The DON confirmed if there's not enough staff to take care of the resident's this could cause a negative outcome. The DON explained she was told by the Administrator the facility does not have the money or the numbers to get the staff.
On 5/20/21 at 10:00 AM with Regional Director of Operations Manager, revealed the current facility assessment does not guide the facility on staffing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 225}	Continued From page 13	{M 225}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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{M 225}	Continued From page 14	{M 225}		

The Administrator also confirmed the Facility Assessment does not give guidance on competent staffing. The Administrator confirmed the facility should have known they did not have sufficient/competent staff to take care of the needs of the residents. The Administrator confirmed the facility have system failures with staffing.
Removal Plan:
The deficient practice consisted of failing to have sufficient staff to protect residents from abuse, worsening pressure ulcers, failure to administer medications timely, delay in incontinent care, and failure to use lift for transfer. Noncompliance at F725 has affected the following residents:
Failure to Protect Residents from Abuse: Residents: #1, #6, #9
Worsening Pressure Ulcers: Residents: #3, #5, #12, #17
Failure to Administer Medications: Residents #1, #5, #8, #10, #11, #12, #15, & #17 Delay in incontinent Care: Resident: #8
Failure to use Mechanical Lift for Transfer: Residents: #2 and #14
Effective 5/14/21, the Facility Management, with the assistance of Corporate Staff, has actively been recruiting nurses and nurse aides. The Facility continues to employ agency staff as needed to keep staffing numbers within acceptable parameters. The ADON reviewed the schedule on 5/21/21 and again on 5/24/21 and called in additional staff.
On 5/24/21, the Corporate Owner approved for additional Facility staff/agency staff to bring staffing numbers up to acceptable levels and to provide resident care.
Staffing was reviewed with the Facility management team, the Owner, and the Senior Director of Clinical Operations on 5/26/21. It was determined that the Facility had calculated its

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 225}	Continued From page 15	{M 225}		

staffing ratio as one unit instead of two distinct units. Staffing in the general Facility care area was increased to meet state and federal staffing requirements.
Effective 6/05/21, the Transportation Aide resumed assisting the ADON in creating the Certified Nurses Aides' schedule. The schedule will be completed two weeks in advance and will be reviewed by the Administrator and/or Senior Director of Operations to ensure the schedule has adequate coverage. Daily, actual staffing is monitored by the ADON and/or Transportation/Lead CNA by reviewing the schedule and agency staff sign in sheet and verifying actual staff in the building. Effective 05/24/21 the ADON and/or Transportation/Lead CNA will be notified by facility staff if there is staff that fail to report for their assigned shift. When call-ins do occur, the ADON and [or Transportation/Lead CNA will attempt to call in other staff to cover the shift as well as attempt to contact the staffing agency for assistance. If those attempts fail, one of the two will cover the shift as appropriate determined by the position that called in until relieved. If two nurses fail to report for duty on the same shift, then the ADON will call the DON for assistance.
On 5/24/21, the Senior Director of Clinical Operations provided one on one education to ADON and Transportation Aide to include staffing based on acuity and layout, staffing patterns, and shifts. The ADON and the Transportation Aide were educated on nurse staffing and creating a stable staffing pattern for implementation.
Validation:
The SSA (State Survey Agency) validated through interviews with nursing staff including Registered Nurses (RNs), Licensed Practical Nurses, (LPNs), and Certified Nurse Assistants (CNAs) across all disciplines and shifts, the facility

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	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 225}	Continued From page 16 continues to employ agency staff as needed to keep staffing numbers within acceptable parameters. The SSA validated through interview with the Assistant Director of Nursing (ADON), and record review of the nursing schedule revealed ADON reviewed the schedule and called in additional staff. The SSA validated through record review of the staffing schedule and interview with the Assistant Director of Nursing (ADON), the staffing is calculated now with two (2) distinct units. The SSA validated through interview with the ADON, the Transportation Aid assists the ADON in creating the CNA schedule at least two weeks in advance and the ADON monitors staffing schedule and agency staff sign in sheets daily to verify scheduled staff is in the building. The Senior Director of Operations verified the Administrator or the Senior Director of Operations reviews the schedule for coverage. The ADON verified facility staff contacts the ADON or the Transportation/Lead CNA if staff does not report as scheduled for their assigned shift and the ADON or the Transportation/Lead CNA will find coverage and will report to the DON in the event two nurses fail to report for duty on the same shift. The SSA validated through interview with the Lead CNA and ADON and record review of in-service sign in sheet, an in-service was conducted by the Senior Director of Clinical Operations regarding the subject of staffing on acuity, staffing patterns, and shift revealed education was provided for ADON and Lead Certified Nurse Assistant (CNA).	{M 225}		
{M 350}	45.12.1 Reponsiblility	{M 350}		7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 350}	Continued From page 17 1. There shall be a licensed administrator with authority and responsibility for the operation of the facility in all its administrative and professional functions subject only to the policies enacted by the governing authority and to such orders as it may issue. The administrator shall be the direct representative of the governing authority in the management of the facility and shall be responsible to said governing authority for the proper performance of duties. 2. There shall be a qualified individual present in the facility responsible to the administrator in matters of administration who shall represent him during the absence. The persons shall not be a resident of the facility. This Statute is not met as evidenced by: Level IV Based on interviews, record review, job description review, and plan of correction review from 12/04/20, the facility's Administration failed to (1) ensure the facility used its resources effectively, to sustain compliance for staffing to ensure adequate care of residents' needs; (2) implement abuse policies and procedures by recognizing escalating behaviors for prevention of resident to resident abuse and protection of residents; (3) report potential and actual abuse to State Survey Agency and local authorities; (4) ensure care of resident needs to prevent development and worsening of pressure ulcers; (5) ensure medications were available and administered to residents routinely and timely for 24 of 24 residents out of a total of 65 residents. The facility's failure to have effective administrative oversight, implementation, and monitoring of its resources resulted in a situation that is likely to cause serious injury, impairment,	{M 350}	1. On 5/6/21, the Regional Director of Operations issued a written corrective action to the Administrator regarding abuse and neglect, including the failure to report alleged violations. Effective 5/26/21, the Regional Director of Operations was terminated. A new Regional Director of Operations has been hired with a start date of 07/01/21. Effective 5/26/21, the Senior Director of Operations, Region 2 Regional Director of Operations and/or the Owner provided direct oversight of the former Administrator until the new Administrator began on 06/21/21. Effective 6/12/21, the Facility'□s Director of Nursing was terminated from her position and an interim Director of Nursing was appointed. There was no lapse in coverage of an Administrator. The Senior Director of Operations and Region 2 Regional Director of Operations provided oversight in the changing of Administrators to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 350}	Continued From page 18 harm, or death to residents. This situation resulted in an Immediate Jeopardy, and the State Agency identified the Immediate Jeopardy (IJ) on 5/21/21. The IJ was determined to exist on 11/17/21, when medications were not available as ordered, and the IJ was not removed prior to exit on 05/26/21 and is considered ongoing. The IJ existed at M350. The IJ was not removed prior to the State Agency (SA) exit on 5/26/2021 and was considered ongoing. The facility provided a Credible Removal Plan, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interviews and in-service sign-in sheets review. The facility provided evidence the facility had implemented corrective actions listed in the Credible Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ M350 has been lowered from the severity of a Level IV to the severity of a Level II. The facility will remain out of compliance at Severity of a Level II that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness	{M 350}	ensure a smooth transition, continuity of care. 2. All residents have the potential to be affected by the deficit practice cited. 3. New Administrator started 6/21/21. New regional director of operations started 7/1/21. Interim DON in place and new DON hired will begin 7/21/21. 4. Beginning 6/29/21 Administrative oversight log will be utilized to document administrative oversite daily by the Administrator or Administrator in training. Findings will be brought to Quality Assurance Performance Improvement monthly beginning 7/2/21 for review, revision, or resolution of the plan for six months. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance. The Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 350}	Continued From page 19	{M 350}		

of the systemic changes to ensure the facility sustains compliance with regulatory requirements.
Findings Include:

A review of the job description entitled "Nursing Home Administrator (NHA)" documented, "As Nursing Home Administrator, you will be responsible for the overall operations, leadership' management, and success of the facility in accordance with resident/employee needs, government, regulations, and company policy. Responsible for financial management, quality assurance, regulatory management, business development goals and maximization of revenue, family relations, and resident care. In addition, responsible for attracting and retaining top performing talented team members as well as the supervision and career coaching team members on staff.

Essential duties of the Administrator include: direct and coordinate medical, nursing, and administrative staffs and services; implements and coordinates policies and procedures for various departments, conducts regular rounds to monitor delivery of nursing care and operation of support departments; ensures consultants and other support resources are appropriately utilized; direct hiring and training of personnel, oversees Quality Assurance and Performance Improvement (QAPI) standards; maintains working knowledge of governmental regulations."

Review of the Administrator's license revealed the licensure was issued on April 1, 2021. The previous Administrator had resigned.

On 05/20/21 at 2:00 PM, an interview with the Administrator revealed he reports to the Regional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 350}	Continued From page 20	{M 350}		

Corporate Operations Manager who develops policies. The Administrator stated it is the responsibility of the Administrator to make sure the policies are followed. The Administrator stated he is responsible for writing the Facility Assessment; however, the Administrator confirmed the facility's current assessment is not sufficient to meet the needs of the residents in this building. The Administrator confirmed the assessment does not give guidance on staffing, wound care and lifts.

The Administrator stated that he would need to make some corrections to the Facility Assessment. The Administrator explained the Department heads meet every morning to discuss issues, concerns, and deficient practice in the facility and the QAPI team meets monthly to discuss high risk issues. He confirmed that he should have known the facility did not have sufficient/competent staff to take care of the needs of the residents.

The Administrator said that during the last QAPI meeting in April the team discussed that some medications were not given as ordered. The plan from QAPI was for the DON to call the pharmacy when a medication was not available. The Administrator also said the QAPI team discussed the wound care assessment documentation not being done. The plan again was for the DON to assess all the wounds and put documentation in the resident's charts.

The Administrator confirmed the facility has system failures with the wound care, staffing and medication administration. The Administrator also confirmed he failed to report the resident-to-resident abuse incidents. The Administrator said he previously worked in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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{M 350}	Continued From page 21	{M 350}		

Louisiana and was told that in Louisiana it was not required to report verbal abuse. He denied being aware a resident was hit, and hair was pulled until the State Agency investigated the complaint. The Administrator confirmed he did not talk to the resident until after the SA interviewed the resident. The Administrator also confirmed he did not report a suspicious fracture. The Administrator said he put it on his calendar to remember to send in the investigation, but he forgot. The administrator said he received a copy of the resident X-ray reports and noted he had a fracture to the tibia.

In the interview continued on 05/20/21 at 2:00 PM, the Administrator confirmed the facility should have known they did not have sufficient/competent staff to take care of the needs of the residents. The Administrator said he thought it was okay to piece the schedule together. He said he let some Certified Nurse Aides work 2 or 3 hour shifts to make up for the shortage.

The Regional Director of Operations (RDO) stated the Administrator is responsible for having an appropriate facility assessment. The RDO confirmed the facility was aware of the problem with getting the resident's medications, but the facility has a back-up pharmacy. The RDO stated deficient practice started from the COVID-19 pandemic with the prior DON because the facility did not have enough staff.

An interview on 05/20/21 at 12:30 PM with a facility physician said she had met with the Administrator and Director of Nursing (DON) about her concerns several times and reported several issues in December about low staffing and medication problems. The Physician stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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{M 350}	Continued From page 22	{M 350}		

the Administrator stated that the facility had a contract with the local pharmacy to receive three to seven days' worth of medication until the routine medication came in. The Administrator said the facility was going to bring in agency staff.

Review of the 2567 and Plan of correction from survey on 12/04/20 with a completion date of 01/26/21 revealed the facility had failed to follow the plan of correction related to cited staffing deficiencies. The plan of correction read:
1. State Agency entered building on 12/2/2020, facility was notified on 12/04/2020 that there was not sufficient staff for 12/02/2020. When next notified of possible staffing shortage on December 11th, 12th and 13th, Director of Nursing (DON) called Administrator who called Regional Director of Operations. All employees on call sheet were called. Staffing agency was called on December 11th to provide coverage. Staffing agency was able to provide coverage and facility agreed to guarantee two nurses and two certified nursing assistants (C.N.A.) slots for the next two weeks and pay hazard pay. Agency was able to provide needed employees.
2. All residents have the potential to be affected by this deficient practice.
3. Nurses were in-serviced on staffing on December 14,2020 by Administrator, Quality Assurance and Performance Improvement plan was completed December 14, 2020 by the Administrator. System changes put into place to ensure the problem does not recur include computerized schedules, proper use of daily staffing sheets, and review of staffing in department head meeting. Charge nurses for each shift will notify DON via facility cell phone if sufficient staffing is not in place or call-ins or no-shows occur. Charge nurse for each shift will text DON number of nurses and C.N.A.s so that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 350}	Continued From page 23	{M 350}		

we may ensure adequate staffing, DON will log calls on call log sheet.
4. Staffing schedules have been placed into Smartlinx on December 23. Assistant Director of Nursing (ADON) started completing daily staffing sheets on December 14 and went back to December 5, ADON will turn in staffing sheets to Administrator. ADON will spot check staffing 3 times per week for 6 weeks then as needed and will document on Staffing Reconciliation Sheet. Administrator will confirm staffing and sign off on sheets. Facility will monitor its performance to ensure solutions are sustained by computing daily required nursing hours to ensure above standard of 2.8. Finding will be presented to Quality Assurance Committee (QA) who will review and make recommendations regarding staffing. QA committee will review monthly for 3 months then as needed.

Interview on 05/25/21 at 12:32 PM with the Assistant Director of Nursing (ADON) revealed as soon as the facility achieved compliance from the 12/04/20 survey deficiency, the facility pulled out the agency staff. She stated the facility has been short ever since.

Removal Plan:
On 5/6/21, the Regional Director of Operations issued a written corrective action to the Administrator regarding abuse and neglect, including the failure to report alleged violations.
Effective 5/26/21, the Regional Director of Operations was terminated and the Senior Director of Operations currently seeking to hire a replacement.
Effective 5/26/21, the Senior Director of Operations and/or the Owner has provided direct oversight of the current Administrator.
Effective 6/10/21, the Facility's Director of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 350}	Continued From page 24 was terminated from her position and an interim Director of Nursing was appointed. A new Administrator was hired with a committed start date of 6/21/21 to replace the current Administrator. There will be no lapse in coverage of an Administrator. The Senior Director of Operations will provide oversight in the changing of Administrators to ensure a smooth transition, continuity of care, and is scheduled to orient the new Administrator on all action plans to resolve the deficiencies cited in the recent survey. Validation: The SA validated through review of written disciplinary corrective action to the Administrator by the Regional Director of Operations. regarding abuse and neglect, including failure to report alleged violations. The SA validated through an interview with the Senior Director of Operations the Regional Director of Operations was terminated. The SA validated through interviews with the Senior Director of Operations, direct oversight of the current administrator has been provided by the Regional Director of Operations, the Senior Director of Operations, and the Owner. The SA validated through interviews and record review of the termination report, the DON was terminated, and the facility has an interim DON on staff. The SA validated through staff interviews a new administrator has been hired and the Senior Director of Operations verified the new administrator will start on 6/21/21.	{M 350}		
{M 500}	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:	{M 500}		7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 500}	Continued From page 25 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other	{M 500}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 500}	Continued From page 26	{M 500}		

residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 500}	Continued From page 27 of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented	{M 500}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 500}	Continued From page 28 by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level IV Based on observation, staff and resident interviews, facility policy review, and hospital discharge recommendations, the facility failed to ensure residents were protected from abuse as evidenced by: 1) Resident #1 yelling at residents, hitting residents, and pulling the hair of Resident #6, and physical contact with Resident #9. 2) The facility staff failed to follow the no manual lift policy. The facility staff also failed to follow the mechanical lift policy requiring two (2) persons assist with transfer which resulted in major injuries for Resident #2 and Resident #14. The facility failed to ensure residents were protected from abuse and neglect for five (5) of 24 residents reviewed for abuse and neglect. The facility's failure to ensure resident's rights to be free from abuse and neglect. The facility's actions placed these and other vulnerable	{M 500}	1. Residents # 1□'s incidents have been thoroughly investigated by the Interdisciplinary Team and recommendations have been stated. Resident #1 was noted with acute behaviors of hitting and pulling Resident #6 hair and was transported to the Oceans Behavioral Health on 4/20/2021 per physician orders. Resident #1 returned to facility on 4/30/21 from behavioral health. On May 4th Resident #9 was hit and pushed by Resident #1. Resident #1 was sent to behavioral health on 5/4/21. Behavioral health facility notified on 5/7/21 that facility was discharging resident to their services on 5/7/21. Resident #6 was evaluated by Social Services Director (SSD) on 4/20/2021 for any psychosocial needs and was determined that no medical evaluation was warranted. The Psychiatric Nurse Practitioner evaluated Resident #6 on 5/07/21. and received	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 500}	Continued From page 29 residents in a situation that would likely cause serious harm, injury, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) on 5/20/21 and determined to be effective on 3/17/21 when Resident #1 was admitted to the facility and physical/verbal abuse of other residents occurred. The IJ and Substandard Quality of Care (SQC) existed at M500-Resident's Rights The IJ was not removed prior to the State Agency (SA) exit on 5/26/21 and was considered ongoing. The facility provided a Credible Removal Plan, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interviews and in-service sign-in sheets review. The facility provided evidence the facility had implemented corrective actions listed in the Credible Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for M500 has been lowered from the severity of a Level IV to the severity of a Level II. The facility will remain out of compliance at the Severity of Level II that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness	{M 500}	Pastoral Consultation on 5/25/21. Resident #9 was evaluated by SSD on 5/6/21, evaluated by the Psychiatric Nurse Practitioner on 5/7/21, and received Pastoral Consultation on 5/25/21. Resident #2 and #14 □ On 4/27/21 Resident #2 was transferred to hospital for x-ray per MD orders. Daughter notified of incident on 5/4/21. Xray revealed fractured left distal Upper 3rd tibial diaphysis. On 5/21/21 Resident #14 was transferred to hospital for x-ray per MD order following fall from bed. Xray revealed fracture to left hip. Each resident'□s care plan was checked to ensure use of Mechanical lift had two person-assist and was included on their care plan on 5/6/21. Care plans were correct with two person- assist. May 7, 2021 The Psychiatric Nurse Practitioner assessed residents for psychosocial concerns in relation to the aggressive behaviors of Resident #1 as well as those residents with documented behaviors. No new orders were given. Administrator and Director of Nursing (DON) reviewed the event and findings of Resident #2 and #14 with the Medical Director on 5/4/21. On 5/4/21 Certified Nurse Aide (CNA) #3 was removed from the schedule and received a written disciplinary for failure to use the mechanical lift as stated in the Care Plan for Resident #2. CNA #3 was terminated on 6/09/21. On 5/21/21 CNA #11 was suspended and later terminated on 5/24/21 due to not using the mechanical lift as stated in the Care Plan for Resident #14. 2. All residents have the potential to be affected by the deficit practice cited. 3. On 5/6/21, 5/8/21, and 5/21/21 the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 500}	Continued From page 30 of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: The facility's, "Behavioral Health Services" policy, undated, stated it is the policy of the facility to provide all residents the necessary behavioral health care and services to assist him or her to reach and maintain the highest practicable level of physical, mental, and psychosocial functioning in accordance with the comprehensive assessment and plan of care. This policy stated behavioral health care plans will be reviewed and revised as needed, such as when interventions are not effective or when the resident experiences a change in condition. The facility's, "Freedom from Abuse, Neglect, and/or Exploitation Prevention Plan Education" policy, revised on 11/14/17, noted the resident has the right to be free from abuse, neglect, misappropriations of resident property and exploitation by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardian, friends, or other individuals. Abuse-The willful inflection of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. a. Physical Abuse-Includes hitting, slapping, pinching, and kicking. It also includes controlling	{M 500}	QAPI Committee met and reviewed the policies in relation to Abuse, Neglect and Misappropriate of Property and use of Mechanical lift. All members agreed on training plan. All staff including agency staff will have education done by facility management staff prior to working in the facility and annually. Beginning 5/6/21 the Regional Nurse and Administrator conducted multiple mandatory in-services with all nurses (RN, LPN, CNAs) and facility employees including abuse, neglect, aggressive behaviors. On 5/6/2021 at 3:52 PM an educational in-service on Freedom from Abuse and Neglect and Reporting Abuse and Neglect was held by Regional Director of Operation (RDO) for Department Heads - Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON/ICC), Maintenance Director, Human Resources/Business Office Manager (HR/BOM), Dietary Manager (DM), Medical Records Director, Social Service Director (SSD), Housekeeping Supervisor, Minimum Data Set Coordinator (MDS Coordinator). Mandatory in-services were conducted with all nursing staff (Registered Nurse, Licensed Practical Nurse, Certified Nursing Aide, Therapy staff) by Regional Consultant and/or Staff Educator concerning a case study of residents involved and policy on use of Mechanical Lift. The ADON/ICC and Nurse Consultant reviewed the current policy on Mechanical Lift for any needed revisions on 5/23/21. No recommendation made. Beginning 5/28/21 the Rehab Director checked off all nursing staff including Certified Nursing Aides with a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 500}	Continued From page 31 behavior through corporal punishment. b. Mental Abuse-Includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. c. Psychosocial Harm-Include but are not limited to extreme embarrassment, ongoing humiliation, degradation as a human being. d. Neglect-Failure of the facility, it is employees or service providers to provide goods and services to a resident necessary to avoid physical harm, mental anguish, or emotional distress. 1. Any employee who witnesses or has cause to suspect abuse/neglect/misappropriation of property/or exploitation of a resident must report it immediately to the Administrator/Director of Nursing of the facility. Record review of the facility's last Dementia training dated January 21 ,2020, revealed the facility had a Virtual Dementia training with the facility staff. A review of Resident #1 Pre-Admission Screening (PAS) dated 3/30/21, revealed Resident #1 has a diagnosis of Alzheimer's Dementia. The PAS also revealed Resident #1 does not have a diagnosis or history of a major mental illness. The PAS revealed Resident #1 takes, and has a history of taking, psychotropic medication. A review of the facility's Comprehensive Care Plan dated 4/15/21, revealed Resident #1 has impaired cognitive function/dementia or impaired thought process related to Dementia and has difficulty making decisions. Resident #1 also experiences Short- and long-term memory loss. The intervention was to engage the resident in simple, structured activities that avoid overly demanding tasks. Resident #1 also has an Activities of Daily Living (ADL) self-care	{M 500}	competency checklist based on return demonstration or verbal demonstration on use of Mechanical lift. The Psychiatric Nurse Practitioner will continue to monitor the residents listed above for potential psychosocial concerns in relation to Resident #1, residents with documented behaviors and those residents receiving psychoactive medications. Psychiatric Nurse Practitioner will monitor all residents bi-monthly. This is an ongoing process. 4. The Director of Social Services for the management company, facility Social Services or Life Connections Coordinator will review progress notes for new behaviors daily times three months. Three residents will be selected to ensure appropriate interventions and updated care plans weekly times four weeks beginning 6/14/21 and monthly times three months beginning 7/14/21. The Rehab Director, Assistant Director of Nursing, or Minimal Data Set nurse will monitor the use of mechanical lifts weekly times four weeks beginning 7/1/21 and then monthly times three months beginning 8/1/21. Findings will be brought to Quality Assurance Performance Improvement monthly beginning 7/2/21 for review, revision, or resolution of the plan for six months. Quality Assurance and Performance Improvement minutes will be reviewed by the Regional Director of Operations or Regional Nurse Consultant monthly beginning 7/01/21. Independent monitoring by an outside consulting firm which began 6/7/21 is being performed for compliance assistance. The Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 500}	Continued From page 32 performance deficit related to aggressive behavior and confusion. Resident #1 has the potential to be aggressive with staff and other residents related to anger, dementia, and poor impulse control. Resident #1's interventions included (1) administering medications (2) analyzing time of day, places, circumstances (3) assessing and anticipating the resident's needs, triggers and what de-escalates behavior. Resident #1 has communication problems related to cognitive communication deficiencies. The facility intervention is to cue, reorient and supervise as needed. Resident #1 has a mood problem related to known physiological condition with manic features. A review of the facility's Physicians' orders dated May 7, 2021, revealed Resident #1 Alprazolam (mg) 0.5 milligrams orally daily for anxiety, Aricept 10 mg orally at bedtime for dementia, Buspirone HCL 10 mg orally twice a day for anxiety, Namenda 5 mg orally twice a day for dementia, Olanzapine 10 mg orally three times a day for psychosis and Seroquel 300 mg orally at bedtime for psychosis. A review of the facility's Nurses' Notes dated 4/20/21 at 11:06 AM, revealed Registered Nurse (RN) #2 overheard Resident #6 say "don't touch my hair." The note revealed RN #2 got up from the nurse's station to see what was going on. RN #2 heard Resident #1 say "I'm going to kill your God D**n A**." Resident #1 repeated the statement two more times. Observation 5/4/21 at 1:14 PM of Resident #1 pacing up and down the facility hallway speaking in a loud tone and cursing with balled fists. Resident #1 was not wearing shoes or a mask. The facility Administrator attempted to redirect the	{M 500}	will report to the Governing Body and the Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 500}	Continued From page 33	{M 500}		

resident and was unsuccessful. Resident #1 approached the State Agency (SA) pushing her in the chest with his pointer finger. The resident was redirected by facility staff.

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

During an interview on 05/5/21 at 1:15 pm, with the Director of Nurses (DON) revealed the DON did not talk to resident #6 about Resident #1 hitting her. The DON said she was not part of the admission process when Resident #1 was admitted to the facility. The DON said she told the Administrator that this facility cannot meet the needs of the resident. The DON said Resident #1 is a danger to himself and others. The DON said the staff told her Resident #1 pulled Resident #6's hair and verbally threatened her. The Doctor wrote orders to send him to a local Behavioral Unit.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 500}	Continued From page 34	{M 500}		

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

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

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

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

On 5/5/22 at 10:15 AM, with RN #3 said she was sitting at the nurse station on the Alzheimer's Unit (AD) and heard Resident #6 say "do not touch my hair again". The nurse said she did not see Resident #1 hit Resident #6. The nurse said by the time she got down the hall Resident #1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 500}	Continued From page 35	{M 500}		

yelling and threatening Resident #6. Resident #1 said I am going to kill you, "B***h." The nurse said she separated the residents. RN #3 said she has asked the DON and the Administrator several times to send Resident #1 out. The nurse said Resident #1 is dangerous and she is afraid he is going to hurt one of the residents or the staff. RN #3 said Resident #1 is hard to redirect.

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

On 5/5/21 at 10:45 AM, in an interview with The Activity Coordinator (AC) for the AD unit said she was responsible for doing Dementia training with the staff. The AC said the staff was trained on hire and annually. The AC said the staff has not been trained in over a year since the pandemic began. The facility has hired several new staff that has not been trained on Dementia care. The AC said when Resident #1 was on the AD unit she had to do one on one activities with him because his attention span was short. The AC coordinator said he was hard to redirect. He would yell and scream at the other residents.

On 5/5/21 at 11:15AM, in an interview with The Business Office/Admissions Manager (BOM) said she is responsible for accepting referrals to the facility. The BOM said she does not have any assessment training. The BOM said she has worked in a nursing home for several years. The BOM said the Administrator sent her to a local

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 500}	Continued From page 36	{M 500}		

nursing home to look at Resident #1, to determine if this facility could meet the needs of the resident. The BOM said the resident was quiet and was not acting out. The DON of that nursing facility said Resident #1 needs to be on a locked unit because he likes to wander and their facility does not have a locked unit.

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

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

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

On 5/5/21 at 1:15 PM, in an interview with the DON, she confirmed the facility has not completed Dementia training since the COVID-19 pandemic. The staff has not had any psychiatric (psych) training. The DON said she was not involved in the admission process. The Corporate office, and the Administrator decides which residents are admitted to the facility. The DON said she did not approve Resident #1's admission. The DON said after the resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 500}	Continued From page 37	{M 500}		

admitted she told the Administrator Resident #1 is difficult to redirect and the facility cannot meet his needs. The DON said Resident #1 has a lot of psychiatric problems. The DON said the staff and the residents are afraid of this resident. She was told they will have to keep the resident and find a way to meet his needs.
On 5/5/21 at 1:30 PM, in an interview with the PNP said she has not been in the facility since March 2020. The PNP said the facility refused to allow her to come in the facility due to Covid-19. The facility called her and asked her to come back to the facility on 05/5/21. The PNP said she assessed and monitored the residents on the AD and the residents that have behaviors. The PNP said she monitors the residents' medications. The PNP said she will be visiting the residents twice a week. The PNP said she will review all Residents that are on psychotropic medications at that time.

On 5/11/21 at 4:35 PM, in an interview with License Practical Nurse (LPN) #14, revealed she worked the AD unit with Resident #1. LPN #4 said Resident #1 cursed the staff and other residents all the time. LPN #14 said Resident #1 continued to call them "b*****s and M****r F*****s" the whole shift. LPN #14 also said Resident #1 is hard to redirect and is impulsive. He runs up to the other resident's faces and draws his fist, yells, and curses at them. LPN #14 confirmed she has not had any behavior or dementia training. LPN #14 said she did not know what to do for Resident #1. LPN #14 said she reported to the DON and the Administrator that the staff did not know what to do to take care of Resident #1 and that he was a danger to himself and the other residents. LPN #14 said she was told to call the doctor and report his behavior. LPN #14 said she was calling the doctor every hour and the doctor finally said do not call her again, call the Administrator because

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 500}	Continued From page 38	{M 500}		

he refuses to send the resident to a behavioral health unit. LPN #14 said the Administrator said he could not send the resident out because his census was low, and he had to keep every resident he could in the building. LPN #14 said she told the Administrator that it is not right that the facility will not get this man some help and causes the other residents to be fearful in their home. LPN #14 said this is the most horrible place, "I've ever worked."

Record review of the Admission Record revealed the facility admitted Resident #1 on 3/17/2021, with the diagnoses that included Dementia with Behavioral disturbance, Epilepsy, Mood disorder and Psychosis. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/26/21, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) of 00 that indicated Resident #1 is cognitively impaired.

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 500}	Continued From page 39	{M 500}		

the nurse's station. Resident #1 was sent out to the local behavior unit on 05/4/21.

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

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

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

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

Record review of the Admission Record revealed Resident #22 was admitted to the facility on 2/11/2021with diagnoses that included Diabetes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 500}	Continued From page 40 Mellitus, Hypertension and Cerebral Infarction due to Occlusion or Stenosis of right Middle Cerebral Artery. Resident #22's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/23/21, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) of 12 that indicated Resident #22 is cognitively intact. On 05/5/2021 at 3:00 PM, in an interview with Unsampled Resident C said she is afraid of Resident #1. Unsampled Resident C said Resident #1 pushed her and almost caused her to fall. Unsampled Resident C also said she did not like going in the day room on the AD unit because Resident #1 would yell, scream, and curse at her and the staff. Unsampled Resident C said she was afraid he would hit her with his fist because he would ball it up at her and the staff. Record review of the Admission Record revealed Unsampled Resident C was admitted to the facility on 11/12/2019 with the diagnoses that included Dementia with behavioral Disturbance, Diabetes Mellitus, and Anxiety and Depression. Unsampled Resident C's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/13/21 revealed Unsampled Resident C had a Brief Interview of Mental Status (BIMS) of 9 that indicated Resident #9 is mildly cognitively impaired. 5/6/2021 at 3:00PM, in an interview with Resident #1's brother he said Resident #1 got in trouble all his life. The brother said they lived together for the last 10 years. Resident #1's brother said Resident #1's behavior continued to get worse. Resident #1 would fight him. He could not handle	{M 500}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 500}	Continued From page 41 him. Resident #1's brother said Resident #1 urinated and had a bowel movement on the floor. The brother also said Resident #1 cut him with a knife like a dog. The brother said he could not do anything with him. He placed him in the local nursing home because he could not handle him. Record review of the facility's "Mechanical Lifts" policy, dated April 18, 2008, revealed, "Policy: "In order to facilitate a safe lifting environment for staff and residents, mechanical lifts are to be utilized for lifting and transferring residents whenever possible. The mechanical lift program will include the following components: *Resident assessment * Staff training for safety and operation of mechanical lifting devices ... Resident Assessment Residents will be assessed upon admission, quarterly, and with any significant change in condition for lifting and transferring needs and to determine the appropriate method and equipment needed to lift/transfer the resident. This assessment is to be completed by the Registered Nurse or Licensed Physical Therapist. This assessment will identify the type of equipment needed, sling type and size, and number of staff needed to complete the lift or transfer. The assessment will become part of the resident's medical record. The lifting/transferring needs and type of equipment needed will be added to the resident's plan of care and this information made available to unlicensed personnel ... Staff Training Any staff member responsible for lifting and/or transferring residents will receive training on the	{M 500}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 500}	Continued From page 42 operation of mechanical devices, application of slings, and safety measures based on the equipment manufactures recommendations. The training must be completed, and competency demonstrated prior to lifting and/or transferring residents..." The manufacturer's, "User Instruction Manual", for the Hoyer HPL700, revealed "2. Safety Precautions ...WARNING DO NOT lift a patient unless you are trained and competent to do so ...6. Operating Instructions ...CAUTION Have someone assist you when attempting to transfer a patient." The User Manual for the Stand-Up Patient Lift, RPS350-1-I from the manufacture revealed staff should observe a trained team of experts perform the lifting procedures and then perform the entire lift procedure several times with proper supervision and a capable individual acting as a patient. The stand-up lift may be operated by one healthcare professional for all lifting preparations, transferring from and transferring to procedures with a cooperative, partial weight-bearing patient. However, since medical conditions vary, Invacare recommends that the healthcare professional evaluate the need for assistance and determine whether more than one assistant is appropriate in each case to safely perform the transfer. The use of the patient lift by one assistant should be based on the evaluation of the healthcare professional for each individual case. The facility's," Lifting Policy", revealed an acknowledgment "This is to certify that I am not to lift any resident without first obtaining assistance. I hereby agree not to lift any resident by my efforts alone ..."	{M 500}		

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	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 500}	Continued From page 43 Resident #2 A record review of the facility's investigation related to Resident #2, revealed a statement from CNA #3 stated, she did not notice any concerns while providing care to Resident #2 on 4/22/21. A review of a statement by CNA #2 revealed she entered Resident #2's room, CNA #3 picked up the resident and placed him in the bed. CNA #2's statement revealed she heard a pop sound and asked CNA #3 was that the resident's leg? CNA #2's statement revealed that CNA #3 thought it was the bed that made the popping sound. CNA #2's statement revealed that CNA #3 stated, "Ain't nothing wrong with him", and then walked out of the room. On 5/6/21 at 3:00 PM, in an interview with the DON revealed the ADON took the statements from all the nurses of what happened the day the resident was injured. The DON said the Administrator finished the investigation and reported it to the SA. The DON said CNA #2 told her that CNA #3 transferred Resident #2 without a lift. Both CNAs were in the room. CNA #2 said she heard a pop and asked CNA #3 if that was the resident's leg. CNA #3 said no that was the bed. CNA #2 stated ok and left the room. The DON stated CNA #2 did not report the incident to the nurse or anybody in the facility until she was asked for a statement. The DON said after she received a statement from CNA #2 the facility determined the fracture was caused by the CNA #3 during transfer. CNA #3 has not been back ever since the incident occurred. The DON stated the Administrator reported the incident to the SA. On 5/4/2021 at 10:30 AM, in an interview with Resident #2's daughter stated she received a call	{M 500}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 500}	Continued From page 44	{M 500}		

from a friend letting her know Resident #2's left leg was swollen and twisted. Resident #2's, daughter said she called the facility and was told they do not know what happened to Resident #2's leg. The daughter said she talked to the Medical Nurse Practitioner (MNP) who said this resident has a fracture to his left leg, but she did not know how it happened.

On 5/4/21 at 2:00 PM, in an interview with the MNP, she stated she was informed on 4/25/21 by the nurse that Resident #2 had a bad skin tear to the left lower leg. The MNP said the resident's leg was really swollen and she was unable to palpate a pulse in the resident's leg. The MNP said she came back on 4/27/21 to re-evaluate Resident #2's, leg and noted it was flaccid and twisted. The MNP said she called the Medical Director and said the resident needed to go to the hospital for an X-ray to the left leg. The X-ray revealed an acute oblique fracture involving the distal 3rd of the left tibial diaphysis with slight lateral displacement of the distal fracture fragment. The MNP said she talk to the Administrator and the Director of Nursing (DON) saying an investigation needs to be done because Resident #2 could not have received a fracture like this from a bump on the bed. The MNP said she told the Administrator that she would have to report this to the State Agency (SA). The MNP said she called it in to the SA on the hotline as an anonymous complaint.

On 5/4/21 at 2:15 PM, in an interview with Certified Nursing Assistant #1 (CNA), she stated she worked the 11-7 shift on 4/22/21. CNA #1 said she did not receive report from any of the other CNA's. CNA #1 said the resident was in the bed when she came in that night and she checked the resident every two (2) hours to see if he had a bowel movement or had urinated. CNA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 500}	Continued From page 45 #1 said she pulled the cover down just to his knee and noted he did not need care. CNA #1 said around 4:30 AM she noted the resident had a large amount of blood on the sheet and said she notified the nurse. CNA#1 said she did not get the resident up that morning. CNA #1 said the resident is care planned to get up with a Hoyer lift with 2 people during transfer. On 5/4/21 at 2:30 PM, in an interview, Licensed Practical Nurse #1 (LPN) stated CNA #1 came to her and reported the resident had dried blood on his sheet around 4:45 AM or 5:00 AM. The nurse said she noted dried blood on the left shin and a thin layer of skin was pulled back on his left leg. The measurements were 6-centimeter (cm)x2.5 cm x0.1cm. The nurse said she cleansed the wound with normal saline, applied topical antibiotic ointment and dry dressing. The nurse said she covered it with a bordered gauze. Tylenol was given for pain. The Physician, DON and Resident Representative (RR) was notified. The nurse said the resident was unable to say what happen to his leg due to confusion. On 5/4/21 at 2:45 PM, in an interview with the Assistant Director of Nurses (ADON), she stated that on 4/27/21, she received a text from the Physician saying that Resident #2 had a large skin tear on his left leg. The ADON stated that she is off work and will check on it when she comes in. An X-ray was ordered by the doctor because they noted increased swelling and limited range of motion. The results came back, and they saw it was a fracture. The ADON started the investigation and interviews with the staff that was providing care to the resident, on the 3-11 shift. The ADON turned all that information over to Administrator.	{M 500}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{M 500}	Continued From page 46 On 5/4/21 at 3:00 PM, in an interview with CNA #2 she stated she works the 3-11 shift. CNA #2 stated she works as needed and has worked at this facility for six (6) or seven (7) months. CNA #2 said she went to Resident #2's room on 4/22/21 to see if CNA #3 needed help with transferring the resident back to bed because he is transferred via Hoyer. CNA #2 said when she came in the Resident #2's room, she asked CNA #3 if she wanted her to get the Hoyer lift. CNA #2 stated that CNA #3 stated, "No I always transfer him without assistance." CNA #2 stated when CNA #3 transferred the resident, by lifting him in her arms. CNA #2 stated she heard a loud pop. She asked CNA#3 was that his leg? CNA #3 said no that was the bed. CNA #2 said the facility is a no manual lift facility and the resident is care planned for a Hoyer lift with transfers. CNA #2 said the care plan is under the task bar where the CNA's chart the residents' care. CNA #2 stated she was in-serviced in February on how to use lifts. The CNA #2 stated she has not been in-serviced on reporting. However, she should have told the nurse, but she was concerned with taking care of her residents. On 5/4/21 at 3:15 PM, in an interview with CNA #3, stated she works the 3-11 shift. CNA #3 said she used the sit-to stand lift to transfer the resident on 4/22/21. CNA #3 said it depends on how the resident is acting that day determines what is used for transfers. CNA #3 said the resident does not have any problems bearing weight. She transfers him all the time with the sit-to stand lift. CNA #3 confirmed she transferred the resident without assistance. CNA #3 stated she did not know about the care plan. CNA #3 stated she did not know the resident was care planned for a Hoyer lift. CNA #3 also revealed she has not had an in-service on reporting.	{M 500}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 500}	Continued From page 47	{M 500}		

On 5/4/21 at 3:30 PM, in an interview with Lead CNA #4 revealed she did an Inservice in February on the lifts. CNA #4 said the CNA's task is in the computer. The Comprehensive Care Plan is in the computer stating how the resident is transferred. This facility is a no manual lift facility. CNA #4 stated the facility requires two (2) people with all lifts. CNA #4 stated it has been over a year since the facility has done any training on abuse/neglect and reporting. CNA #4 stated the new staff has not been in-serviced on abuse/neglect and reporting.

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

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

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

A record review of Resident #2's Diagnosis Information revealed Fracture of shaft of left fibula initial encounter for closed fracture, Lack of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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{M 500}	Continued From page 48	{M 500}		

coordination, Muscle Wasting and Atrophy, Muscle Weakness, and Primary Osteoarthritis.

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 500}	Continued From page 49	{M 500}		

A record Review of the facility's Hoyer and Total lift in-services dated February 10, 2021 revealed the staff was in-serviced on the proper use of the lifts. The in-services instruct the staff to check the residents plan of care for transfer instructions. There shall always be two people with all lift transfers, never lift a resident by yourself. This is a no lift facility.

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

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

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

Resident #14

The facility had not completed investigation prior to state leaving.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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{M 500}	Continued From page 50	{M 500}		

she notified the doctor, and Resident #14 was transferred to a local hospital.

On 05/24/2021 at 3:15 PM, in a phone interview with CNA #11 she stated on 5/21/21 at 9:29 PM she used the sit to stand lift with the resident. She stated she pushed the lift in front of Resident #14 sitting in the wheelchair. She stated she lifted the resident with the sit to stand lift by herself. She stated she did peri care and placed the resident back in the wheelchair. CNA #11 was unable to explain why she used the lift by herself. She stated she felt like she could get the resident with the lift by herself. She stated she was in-serviced on 5/21/21 regarding using a lift. She stated she lifted the resident back up from the wheelchair to put the resident on the bed and thought the resident was sitting on the bed properly. She then removed the lift sling and the resident moved and began to slide out of the bed. She stated she attempted to catch the resident by the arm and was not able to do it. She stated the resident slid off the bed and landed on her left side. She stated she yelled and a CNA in the hallway came to assist her. She stated CNA #15, #16, LPN #4 and LPN #5 lifted the resident off the floor back to the bed, without the lift. She stated LPN #4 and LPN #5 did an assessment on the resident. She stated the resident complained of left leg pain. She stated that while she was assisting the resident with bed linen, she noticed a skin tears to the left elbow and the left leg She further reported she notified LPN # 4 of the blood on the resident's leg. She stated LPN #4 told her to write a statement and leave the facility.

On 05/24/2021 at 3:40 PM in an interview with Assistant Director of Nursing (ADON), she explained she did not do any investigation on the incident. She stated that all individuals who were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 500}	Continued From page 51	{M 500}		

involved in the incident wrote statements. She stated the statements were left in her box. She explained the DON was notified and was the one who did the investigation of the incident.

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

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

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	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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{M 500}	Continued From page 52 A record review of Resident #14's Admission Record revealed she was admitted on 5/20/2015. A record review of Resident #14 Comprehensive Care Plan reveals transfer extensive x 2 mechanical HOYER lift with size ex-large sling, dated 2/11/2016 and revised on 1/22/2020. A record review of Resident #14's Diagnoses Information revealed Hemiplegia and Hemiparesis following Cerebrovascular Disease affecting left non-dominant side, Lack of Coordination, other Muscle Spasms, Muscle Weakness and Muscle Wasting. A record review of the in-service dated 5/21/21 on Mechanical Lift Safety Use, revealed the CNA #11's signature was on the sign in sheet. A record review of the local hospital X-ray report dated 4/27/21, revealed moderately displaced intertrochanteric left proximal femur fracture or pelvic fractures in the field of view and moderately displaced intertrochanteric left proximal femur fracture. A record review of the local hospital admission dated 4/27/21 revealed a diagnosis of a Fracture left trochanteric unspecified, closed. Removal Plan: The failure to ensure resident's rights to be free from abuse and neglect. Noncompliance at F600 has the potential to affect ail residents in the Facility. Residents # I's incidents have been thoroughly investigated by the Interdisciplinary Team and recommendations have been stated. Resident #1 was noted with acute behaviors of hitting and	{M 500}		

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{M 500}	Continued From page 53	{M 500}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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{M 500}	Continued From page 54	{M 500}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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{M 500}	Continued From page 55	{M 500}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{M 500}	Continued From page 56	{M 500}		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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{M 500}	Continued From page 57 reviewed the event and findings of Resident #2 and #14 with the Medical Director. The SA validated through review of the written disciplinary form and termination report, on CNA #3 was removed from the schedule on 5/4/21 and received a written disciplinary form for failure to use the mechanical lift as stated in the care plan for Resident #2. CNA #3 was terminated on 6/09/21. The SA validated through review of the written disciplinary form and termination report CNA #11 was suspended and later terminated due to not using the mechanical lift as stated in the care plan for Resident #14. The SA validated through interviews and review of QAPI sign in sheets, on the QAPI committee reviewed the policies in relation to abuse, neglect and misappropriate of property and use of Mechanical lift. All members agreed on the training plan and training will be provided to agency staff by contracted consultants if they do not have proof of education.	{M 500}		
{M 615}	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level IV Based on observations of staff and residents, staff and resident interviews, record review, and facility policy review, the facility failed to ensure residents received care, consistent to prevent	{M 615}	1. The Certified Wound Care Nurse and MDS Coordinator assessed wounds for staging and treatment on 5/28/21 for Residents #3, #5, 6#, #7, #12, #13, #14, and #17 to ensure correct treatments are	7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{M 615}	Continued From page 58 pressure ulcers, to promote the healing of pressure ulcers, prevent an infection, and prevent new ulcers from developing for eight (8) of nine (9) residents sampled. Residents #3, #5, #6, #7, #12, #13, #14, and #17. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 04/06/2021 when the facility failed to ensure Resident #7's wound was free from infection as evidenced by the wound developed a foul odor and increased drainage. This wound was cultured and revealed an infection present in the wound bed. The facility's failure to ensure residents received care, consistent to prevent pressure ulcers, to promote the healing of pressure ulcers, prevent an infection, and prevent new ulcers from developing placed the residents in a situation that caused or is likely to cause serious harm, injury, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) on 05/05/2021 and was determined to exist on 04/06/2021. The IJ was not removed prior to exit on 05/26/2021 and is considered ongoing. The IJ and Substandard Quality of Care (SQC) existed at M615 Pressure Sores The IJ was not removed prior to the State Agency (SA) exit on 5/26/2021 and was considered ongoing. The facility provided a Credible Removal Plan of IJ, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit in order to determine if	{M 615}	being provided and interventions are appropriate for the wounds identified. Any necessary changes to treatment and medications were reported to the Medical Director on 5/28/21. Any physicians orders were entered at that time and the care plans updated. Resident #3s Care plan was updated by the Minimum Data Set Coordinator and Certified Wound Care Nurse. Residents #5 was discharged on 1/21/21. Resident #6s MDS care plan was updated on 5/21/21. In addition, the Certified Wound Care Nurse assessed the resident for wounds on 5/23/21; no care plan revisions were required after assessment. Resident #7 The MDS Coordinator reviewed the MDS dated 4/18/21. No MDS correction was allowed as the documentation supplied with updated information on wounds was supplied outside of the allowed look back period to use for the MDS assessment per the RAI manual. A Certified Wound Care Nurse assessed Resident #7 on 5/22/21, and on 5/24/21. The MDS Coordinator updated the care plan. Resident #12 Resident was discharged on 5/17/21. No revisions to Section M of the 4/16/21 MDS are necessary as the additional wounds noted occurred and were documented after the allowed assessment period per the RAI manual. Resident #13- A Certified Wound Care Nurse assessed Resident #13 on 5/22/21. The MDS Coordinator updated the care plan on 5/25/21. Resident # 14 The DON completed an assessment of Resident #14s wounds on 5/27/21. The MDS Coordinator updated the care plan on 5/28/21 after the resident returned from a hospital stay spanning	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 615}	Continued From page 59 corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interview, record review, and in-service review. The facility provided evidence the facility had implemented corrective actions listed in the Credible Allegation of Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for M615 has been lowered from the severity of a Level IV to the severity of a Level II. The facility will remain out of compliance at the Severity of Level II that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: The facility's, "Skin Care Process" policy, revealed a date of January 17, 2018. "It is the policy of this facility to provide care and services with the goal of maintaining the resident's skin integrity and to provide care and services that meet professional standards to treat the loss of skin integrity should it occur ...Process: The skin care process has 6 components: 1. Evaluation of the resident's skin condition 2. Determining risk for altered skin integrity. 3. Developing and implementing an individualized plan of care. 4. Evaluating the effectiveness of the plan of care and revising approaches as needed. 5. QAPI system for overall effectiveness of the skin care process. 6. Staff education related to the skin	{M 615}	5/20/21 to 5/27/21. Resident # 17□s □ A Certified Wound Care Nurse assessed the wound on 5/22/21 and the MDS Coordinator updated the care plan on 5/24/21. On 6/03/21, Corporate Management approved for Wound Care Specialists from other facilities to work in the Facility to assist with audits of wounds, wound care, training, and assist with correcting care plans. The Wound Care Specialist began on 6/3/21. All Residents listed have been thoroughly assessed & reassessed regarding the wound care provided to them in the Facility. Care plans have been updated, and education has been provided to all staff regarding: measurements, Braden scale frequency, notification of families about new wounds and status of wounds, and documentation of care provided. The Care Plan Committee implemented comprehensive care plans for Residents #2, 3, 6, 7, 9, 10, 11, 14, 15, 17, 20, 30, and 31 on 5/21/2021 related to wounds and medications. Resident # 4 discharged on 1/29/20, Resident 5 discharged on 1/21/21, and Resident #12 discharged on 5/17/21. The wound care-certified Regional Nurse Consultant educated the Director of Nursing regarding the skin and wound care process including prevention, identification, treatment, documentation, wound vacs, and tracking and reporting wounds on 5/23/2021. 2. All residents with skin integrity concerns have the potential to be affected by the deficit practice cited. 3. The Regional Nurse Consultant contacted American Medical Technologies (AMT) to request an in-service for nursing	

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	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 615}	Continued From page 60 care process. Process Guidelines: 1. Evaluation of the resident's skin condition on admission as as needed. 2. Determining the risk for altered skin integrity: a. The Admit/Readmit Physical Evaluation should be completed on admission and readmission. b. The Braden Scale should be completed upon admission, readmission, quarterly and as needed to determine pressure ulcer risk. c. The Malnutrition Risk Assessment should be completed on admission, readmission, quarterly and as needed. 3. See care plan process. 4. If a wound is not showing signs of improvement within 2 weeks of treatment, a re-evaluation of the wound and change in treatment should be considered. 5. QAPI system for evaluating the overall effectiveness of the skin care process. 6. Staff education: Nursing staff should receive training regarding skin and skin care as appropriate upon hire and periodically thereafter. Nurses may need further training in evaluation, assessment, staging and measuring wounds prior to being responsible for wound care ... Pressure Wounds: The goal of this facility in regard to pressure wounds is to promote the prevention of the healing of pressure wounds that are present and to minimize the potential for development of new pressure wounds using the Skin Care Process." Resident #3 On 05/05/21 at 1:15 PM in an observation of wound care on Resident #3 with Licensed Practical Nurse (LPN) #5 revealed the nurse cleansed a large, opened wound to sacrum with wound cleanser, there were no odors are drainage. The wound bed is pink with maceration around the edges. The nurse cleansed with wound cleanser and packed with Santyl, gauze,	{M 615}	staff related to skin and wounds on 5/21/21. AMT completed an evaluation of Facility residents wounds on 6/4/2021 for any necessary additional changes. The Nurse Practitioner was scheduled to attend a training and education with AMT on 6/4/21 to gain knowledge regarding assessing and staging wounds and the clarification of appropriate wound treatment orders however she refused to attend the training. The Assistant Director of Nursing completed skills competencies with the Regional Nurse Consultant on 5/21/2021 that included routine competencies, skin and wound, behavioral health, and medication administration. On 5/22/21, the Charge Nurses, MDS Coordinator, and Director of Nursing were provided an in-service to educate them regarding the failure to assess and document wounds weekly and to change, develop, or update the residents care plan immediately when wounds change. Beginning 5/6/21, all other residents care plans were evaluated for behaviors and wounds, and a comprehensive plan of care was completed for each resident. CNA competency training--including toileting techniques, turning, and positioning were completed by 6/1/21 by the Lead CNA. On 5/22/21, the Regional Nurse Consultant conducted education for the Director of Nursing, Assistant Director of Nursing/Infection Control Coordinator, and Medical Records Nurse regarding monitoring care plans, medication administration, wound care treatments and documentation, pharmacy services, and communication with Governing Body. Licensed nursing staff completed body	

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	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 615}	Continued From page 61 covered with dry dressing. On 05/06/21 at 1:15 PM in an interview with the Resident #3's daughter revealed Resident #3 acquired the wound in the facility. The daughter said she hired a sitter several months ago to assist the resident because the staff was not turning her and assisting with meals. 0n 5/05/21 at 1:30 PM interview with LPN #5, said explained Resident #3 acquired the wound in the facility. She further explained Resident #3 acquired the wound before she started working at the facility. She reported she does the treatments, but she does not measure the wounds and the DON is responsible for keeping up with the measurements. Record review of Resident #3's Weekly Pressure Injury record dated 09/30/2020, revealed the Stage 3 wound to the sacrum measured 1 centimeter (cm) x 4.0 cm x 0.5 cm with granulation tissue. The next Weekly Pressure Injury Record was dated 1/11/2021 and was blank with no information entered. The most recent weekly Pressure Injury Record was completed on 5/07/2021 and revealed Resident #3 had a Stage 3 pressure ulcer to the sacrum measuring length 4 cm, width 5 cm, depth 0.75 cm and tunneling of 2 cm at 6 o'clock and a Stage 2 pressure wound to the right gluteal fold measuring 1 cm X 1.5 cm X 0.1 cm. Record review of Resident #3's first 03/04/2021 with Wound Care revealed measurement for sacrum Stage 3 pressure injury length 6.0 cm, width 5.0 cm, and depth 0.6 cm. The report revealed large amount of serosanguineous exudate with no tunneling, but wound did have slough noted.	{M 615}	audits on all patients on 5/23/2021, any new skin concerns were addressed at that time. The Regional Nurse Consultant and ADON/ICC began on 5/27/21 and completed on 5/29/21 a review of all residents□ care plans for skin issues, therapeutic medications on their care plans, and any behaviors noted to ensure that the care plans are current and up to date. No RD recommendations were made. Treatment Administration Records are reviewed by the IDT daily in clinical stand up meetings to monitor for omissions. 4. The Director of Nursing or ADON will review the wound care log weekly times four weeks beginning 7/1/21 and then monthly beginning 8/2/21 times three months. Residents identified with wounds will be discussed during the weekly Persons At Risk meeting beginning the week of 7/1/21. Findings will be brought to Quality Assurance Performance Improvement monthly beginning 7/2/21 for review, revision, or resolution of the plan for six months. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance. The Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 62 On 5-13-21 at 9:30 AM, in an interview with (Proper Name) Wound Clinic Wound Care Nurse, Registered Nurse (RN) #2, she explained the facility has three (3) residents that come for wound care. She explained the residents come once every three (3) weeks and the facility does a rotation schedule for the three (3) residents. When asked regarding Resident #3, she explained the resident was referred to wound care on 03-04-21 for a stage 3 decubitus ulcer. She further explained that was all the Resident #3's referral said. She explained she has no start date of the decubitus and not sure exactly when the wound began. She reported Resident #3 was seen years ago for the same wound but in August 2017 the facility stopped sending residents due to the facility wanted to do the wounds in house. Record review for Resident #3's Face Sheet revealed the facility initially admitted Resident #3 on 02/24/2019 with the diagnoses of Atrial Fibrillation, Type 2 Diabetes Mellitus, Pressure Ulcer Sacral Region Stage 3, Hemiplegia and Hemiparesis, Peripheral Vascular Disease, Cardiomegaly, and High Blood Pressure. Record review Quarterly Minimum Data Set with Assessment Reference Date (ARD) dated for 2/15/21 Section C revealed Resident #3 had a Brief Interview of Mental Status (BIMS) score of 05, which indicates severe cognitive impaired. Section G revealed Resident # 3 required two (2) plus person assistance with bed mobility and transfers. Section H revealed Resident #3 was always incontinent of bowel and bladder. Section M revealed Resident #3 had a Stage 3 pressure ulcer. Record review of Dietician Progress notes revealed Resident #3 has been seen monthly	{M 615}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 615}	Continued From page 63	{M 615}		

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

Record Review of Resident #3 Physician Orders revealed wound care order dated for 03/15/2021 and end date of 04/09/2021 states to cleanse sacral decubitus wound with wound cleanser twice daily, apply Santyl to wound bed and cover with large foam border dressing, daily and additionally if dressing becomes soiled. A physician order dated 03/16/2021 states for resident to have a wound care appointment at the (Proper Name) wound clinic every two (2) weeks. A Physician Order dated 04/09/2021 states to cleanse sacral decubitus wound with wound cleanser daily, apply Santyl to wound bed and cover with large foam border dressing. The Physician Orders also included a wound care order dated 04/20/2020 states to cleanse with wound cleanser pat dry apply collagen pad (puracol) to fit into the wound bed with calcium alginate silver ribbon cover with a bordered super absorbent dressing daily one time a day and has a discontinued date of 03/17/2021. An additional order dated 10/30/2019 states to visually check dressing to Stage 3 ulcer every shift and the order was discontinued on 03/19/2021.

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

Record review of Nursing Progress Notes revealed a Patient at Risk (PAR) dated for 3/12/2021 with a care plan meeting with Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 615}	Continued From page 64 #3's daughter and concerns regarding Resident #3's care. The noted revealed a staff member will go with resident to wound care, frequent visual observations to ensure wound care being carried out, and having nurse initial, date, and time the bandages were changed. The note revealed no measurements of the wound. The record revealed the previous PAR note was dated for 07/22/2020 with Stage 3 sacral area measurements 2.5 cm x 2 cm x 0.3 cm with bright pink granulation tissue with white edges related to maceration with no odor and scant amount of serous drainage. Record review of Nursing Progress Notes revealed a Patient at Risk (PAR) note dated for 3/12/2021 with a care plan meeting with Resident #3's daughter and concerns regarding Resident #3's care. The noted revealed a staff member will go with resident to wound care, frequent visual observations to ensure wound care being carried out, and having nurse initial, date, and time the bandages were changed. Record review of Resident #3's Treatment Administration Record (TAR) for January 2021 revealed omitted documentation for the treatment of Stage 3 ulceration to sacrum on 1/1/21, 1/2/21, 1/8/21, 1/9/21, 1/10/21, 1/15/21, and 1/16/21 for a total of seven (7) entries omitted in January. Record review of the TAR for March 2021 revealed omitted documentation for the treatment of sacral wound on 3/9/21, 3/11/21, 3/15/21, 3/22/21, 3/27/21, and 3/28/21 for a total of six (6) entries omitted in March. Review of April 2021 TAR revealed omitted documentation for the treatment of sacral wound on 4/2/21, 4/3/21, and 4/7/21 for a total of three (3) entries omitted in April.	{M 615}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 615}	Continued From page 65 A record review of lab results for Resident #3 revealed Albumin level low at 1.9 dated for 03/24/2021. Resident #5 SA phoned son of Resident #5 on 05/04/21 at 11:00 AM. SA asked him regarding his mom's care while a resident at Liberty Nursing Home, and he explained the first concern was his mother got bedsores while at the facility. Record review of Resident #5's Admission Record revealed the facility admitted Resident on 05/19/2020 with the diagnoses of Hypothyroidism, Major Depressive Disorder, Anorexia, Heart Failure, History of Transient Ischemic Attach (TIA) and Cerebral Infarction without Residual Deficits, High Blood Pressure, Chronic Kidney Disease, Type 2 Diabetes, Unspecified Urethral Stricture, female, Pressure Ulcer of right buttock Stage 2, and Pressure ulcer of left heel, unstageable, which indicated the pressure ulcers to right buttock and left heel were present on admission. Resident #5 was discharged to another facility on 1/21/2020. Record review of Resident #5's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of November 16, 2020, Section C revealed Resident #5 had a BIMS score of 06, which indicated Resident #5 had severe cognitive impairment. Section G of the MDS revealed Resident #5 required extensive assistance with two plus persons. Section H of the MDS revealed Resident #5 had an indwelling catheter and always incontinent of bowel. Section M of the MDS revealed Resident #5 had one (1) Stage 2 and one (1) unstageable wound. The latest Discharge MDS with ARD of 1/21/2021 revealed the same findings as the quarterly MDS.	{M 615}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 615}	Continued From page 66	{M 615}		

Record review of Resident #5's Initial Weekly Wound Pressure report dated 05/20/2020 revealed resident #5 was admitted with a wound on the left heel, inner aspect, unstageable, with measurements of 2 cm x 1.4 cm x 0.2 cm and wound to right buttock Stage two with measurements 1 cm x 1 cm x 0.2 cm. Review of Resident #5's Nurse Progress Notes dated 05/25/2020 revealed a new area to left gluteal fold with partial thickness measurements of 1.5 cm x 0.5 cm x0.1 cm with cleansed area with wound cleanser pat dry, zinc oxide applied to area. There was no weekly body audit with the new wound to left gluteal fold with measurements. Review of Resident #5's weekly body audit dated 06/17/2020 revealed no measurements and continue treatment to coccyx and right foot. Further record review of Resident #5's weekly body audits dated 09/02/20, 09/28/20, 10/14/20 revealed body audits with wounds right and left buttock with no measurements recorded.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 67 denuded area to left buttock cleanse area with wound cleanser and pat dry apply zinc oxide cover area with silicone dressing daily and Stage 2 to right buttock to cleanse with wound cleanser and pat dry, apply zinc oxide 20% to area and cover with silicone dressing daily. A new order dated for 08/03/2020 states unstageable ulceration to left heel (inner aspect) cleanse with wound cleanser and pat dry, apply sure prep to wound bed only, cover with 4x4 and foam heel dressing and wrap with Kerlex and secure with tape every two days. Record review of Resident #5's only lab value record dated 06/03/2020 with an Albumin level 2.8, which indicated a low level. Record review of Resident #5's only Braden Scale dated 09/30/2020 for predicting pressure sores revealed Resident #5 is at high risk for developing pressure sores. Record review of Resident #5's Treatment Administration Record (TAR) revealed when resident first arrived at the facility in May 2020, Resident #5 had missing documentation for treatment to left heel were missed on 05/21/2020, 05/22/2020, 05/23/2020, 05/27/2020, 05/28/2020, and 05/29/2020 and missing documentation for treatment to Stage 2 to right buttock on 05/21/2020, 05/22/2020, 05/27/2020, 05/28/2020, and 05/29/2020. On 5/5/2021 at 3:00 PM, in an interview with the DON, when asked if a treatment is not initialed what does that mean, she reported if it is not documented than it is not done. She further explained the treatments on the Treatment Administration Record should be initialed after the treatment is done.	{M 615}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 68 Resident #6 Interview on 5/2/2021 at 11:00 am with Resident #6's daughter revealed her mother is not cognitively impaired. She reported her mother developed a sore on her ankle while at the facility and still has the sore. She reported the staff does not do the treatments regularly. Observation and interview on 5/6/21 at 3:30 PM, revealed LPN #10 performed a skin assessment on Resident #6. LPN #10 explained Resident#6 has had the wounds for a long time and reports the wound will get better and then open back up. No dressing observed to wounds. Observed LPN #10 measure wounds with a paper ruler for each wound, wounds measurements were documented by LPN #10 to be left ankle 1.5 cm x 1.0 cm and right ankle measurement 1.5 cm x 1.5 cm x 0.2 cm. Both wounds to ankle were covered with blue dye, wound tissue dyed blue with some darker tissue to the center of the wounds, and wounds edges both irregular. The wounds had no drainage. Record review of Resident #6's weekly body audit dated for 01/08/2021 only reports no new skin alterations. Body audits dated 03/02/2021, 04/27/2021, 05/06/2021 revealed no measurements of wound to ankles and no weekly pressure injury records available. A weekly body audit dated 03/03/2021 revealed right and left ankles with both wounds measuring 1.0 cm x 1.0 cm with callous like wound on ankles. Three weekly skin reports provided by the DON revealed on 01/28/2021 Resident #5 had bilateral ankle abrasions with one measurement of 2.0 cm x 2.0 cm; on 03/15/2021 resident had non-pressure wounds to bilateral ankles, the	{M 615}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 69 wounds were facility acquired and a measurement of 2.0 cm x 2.0 cm one set of measurements for bilateral ankles; and on 04/13/2021 facility acquired non-pressure wounds to bilateral outer ankles and a measurement of 1.5 cm x 1.5 cm. A Pressure Report dated 05/08/2021 revealed Resident # 6 with pressure wounds to bilateral ankles with measurements left ankle 1.5 cm x 1.2 cm and right ankle 1.5 cm x 1.5 cm with Stage 2 noted with eschar tissue per DON skin assessment. 05-10-21 at 3:45 PM In an interview with Resident #6 she explained she got the wounds to her ankles years ago and at first the facility did not do anything about them for a long time. She reported that she keeps hitting her ankles on the wheelchair. She reported the facility does paint the wounds with something blue but still does not do it every day. She explained that the areas still hurt with any pressure on the ankles. Record review of Resident #6's Face Sheet revealed the facility initially admitted Resident #6 on 07/31/2017 and readmitted on 01/16/2019 with the diagnoses of Cerebral Infarction, Atrial Fibrillation, High Blood Pressure, and anxiety disorder. The Face Sheet revealed Resident #6 had an added diagnosis of Pressure ulcer Stage 2 to unspecified ankle on 05/07/2021. Record review of Resident #6's Annual MDS with ARD date 2/26/2021 Section C revealed Resident #6 had a BIMS score of 13, which indicated Resident #6 is cognitively intact. Section M revealed Resident #6 had a Pressure ulcer of 1 or greater or a scar over a bony prominence. Section M had no other areas flagged for skin conditions. Resident #6's Quarterly MDS with ARD date 12/08/2020 Section M had no areas flagged for skin conditions.	{M 615}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 70 Record review of Resident #6's Physician Orders revealed orders for date of 1/21/2021 and discontinued date 03/12/2021 for change duoderm dressings to bilateral ankle abrasions every 3 days, fluff bilateral ankles with 4X4 gauze and ace wrap or wrap with Kerlix, check dressing daily to ensure appropriate coverage of wounds, order for clean bilateral ankles with normal saline or wound cleanser, pat dry, apply skin prep and hydrocolloid dressing change every 3 days with start date of 02/02/2021 and discontinued 03/10/2021; Santyl ointment topically every day shift for wound care, clean bilateral ankles with wound cleanser, pat dry, apply Santyl and wrap with Kerlix daily with start date 03/11/2021 and discontinue date 04/04/2021; inspect resident's feet daily every shift, and Gentian Violet solution apply to outer ankle wounds bilaterally topically one time a day for wound care, cleanse bilateral outer ankle wounds with soap and water, pat dry, apply Gentian Violet solutions and wrap with Kerlix start date 04/05/2021. Record review of Resident #6's only Braden Scale report available dated 06/23/2020 revealed Resident #6 was a low risk for predicting pressure sores. Record reveal of Resident #6's most recent lab results dated 05/05/2021 revealed an Albumin level of 3.1. Resident #7 On 05/05/2021 at 7:30 AM, in an interview with LPN #5 during medication administration to Resident #7, the resident received Cipro 500 milligram (mg). When asked LPN #5 why resident was receiving antibiotics, she explained Resident #7 has an infection. When asked what type of	{M 615}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 71	{M 615}		

infection, LPN #5 explained Resident #7 has a wound infection. She explained she will be doing his wound care later today.

On 5/6/21 at 10:30 AM, during an observation of wound care by LPN #5 for Resident #7's sacral wound and right gluteal fold, the sacral wound was observed with a moderate amount of brown, purulent drainage with a foul odor noted. The wound bed tissue was brown and necrotic with some slough noted to the sacral wound. The right gluteal fold wound had 75 % slough with a scant amount of purulent drainage. LPN #5 explained Resident #7 has had the wound to his sacrum for a long time. She further explained the wound had gotten worse since the resident was in the hospital last month. She reported that he used to go to wound care, but not sure when and no longer does. She reported the wound to resident's right gluteal fold was new after his last hospital stay. LPN #5 and SA only observed two (2) open pressure wounds for Resident #7, one to the sacrum and one to the right gluteal fold.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 72	{M 615}		

measuring the sacral wound, she reported "the wound stinks."

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

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

Record review of a weekly body audit dated 07/07/2020 for Resident #7 revealed a sacrum wound Stage 3 with measurements 3 cm x 7 cm x 0.2 cm with bright red granulation tissue. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 73	{M 615}		

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 74 started on 04/22/2021 and another order for Boost two times a day for wound healing started on 04/15/2021. Record review of Nurse Progress notes dated for 04/08/2021 for Resident #7 revealed resident was sent out to the local hospital on 4/08/2021 with the hospital diagnoses of Sepsis and Urinary Tract Infection. Lab reports 04/08/2021 revealed abnormal complete blood count (CBC) with elevated white blood cell counts 19.2 and on 04/09/2021 CBC elevated level of 23.5, urinalysis with positive nitrites, large leukocytes, and urine culture with Escherichia coli, and wound culture collection date of 04/08/2021 with heavy growth of pseudomonas aeruginosa. Resident #7 returned to the facility on 04/13/2021 with a new order of order to start on 04/14/2021 cleanse sacral and hip wound with wound cleanser, pat dry, apply Aquacel Alginate foam pad apply to sacral and hip wound topically one time a day, Augmentin 875-125 milligrams give one tablet by mouth two times a day for infection for 7 days started on 04/13/21 and end 04/20/2021. Record review of nurse progress notes dated 04/15/2021 revealed Resident #7 was sent back to local hospital for altered mental status but returned the same day. Record review of nurse progress notes dated 04/18/2021 revealed Resident #7 was sent back out to the local hospital on 04/18/2021 and admitted with diagnoses of Urinary Tract Infection and Pneumonia and returned to the facility on 04/21/2021. A new Physician order for Moxifloxacin 400 milligrams give one tablet by mouth one time a	{M 615}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 75	{M 615}		

day related to Pseudomonas started on 04/21/2021 when Resident #7 returned from the hospital and order end date 04/28/2021. Record review of wound culture of Resident #7's sacral wound collected on 04/22/2021 revealed heavy growth of pseudomonas aeruginosa with sensitivity report.

Record review of nurse progress notes on 04/26/2021 revealed Resident #7 was unresponsive and sent back to local hospital and resident returned to the facility on 04/29/2021 with diagnosis of Syncope with a new order for Ciprofloxacin 500 milligrams give one tablet by mouth every 12 hours for wound infection for 14 days started on 04/29/2021 and end on 05/13/2021.

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 76	{M 615}		

transfers. Section H of the MDS revealed Resident #7 was always incontinent of bowel and bladder. Section M of the MDS revealed Resident #7 had only one Stage 3 wound.

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

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

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

Resident #12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 77	{M 615}		

granulation tissue. The venous ulcer to left lateral lower leg had no drainage, no odor, and pink granulation tissue. An assessment of the buttocks revealed three (3) open areas to right buttock and one (1) open area to left buttock. All the three (3) open pressure areas to the right buttock and the one (1) pressure area to the left buttock had minimal bloody drainage and no odor with red granulation tissue noted. The SA observed the DON measure the wounds to the right and left buttocks with her index finger and thumb and recorded measurements of right buttock site #1 measured 0.5 cm x 0.5 cm x 0.1 cm, site #2 measured 1.0 cm x 1.0 cm x 0.1 cm, and site #3 measured 1.5 cm x 1.5 cm x 0.1 cm. The SA observed the DON measure the wound to the left buttock with her index finger and thumb and document measurements of 1.0 cm x 1.5 cm x 0.1 cm. The measurements for the right knee were 1.0 cm x 2.0 cm and the DON did not record a depth. The left knee measurements were 3.5 cm x 3.0 cm, and the DON did not record a depth measurement. The left lateral lower leg ulcer was not measured by the DON for measurements. She did not use any type of measuring instrument.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 78	{M 615}		

to move to relieve pressure. He reported that he gives himself bathes from the waist up.

On 5/11/21 at 1:55 PM, an observation of the DON performing a body audit and wound measurements on buttock wounds for Resident #12 revealed three (3) wounds to Resident #12's right buttock and one wound to the left buttock with the DON. The DON explained 2 of the wounds to Resident #12's right buttock was healed on the body audit done 5/8/21. DON measured wounds with a Q-tip applicator package and documented the measurements as right buttock wound #1 as 2.0 cm x 1.5 cm x 0.1 cm, right buttock wound #2 as 0.5cm x 0.5 cm, and 0.1 cm, and wound right buttock #3 as 1.0 cm x 2.0 cm x 0.1 cm. The left buttock had one wound with a measurement of 0.5 cm x 0.5 cm x 0.1 cm. The DON did not measure the abrasions to both knees and the left lateral lower leg venous ulcer.

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

Record review of Resident #12's body audits revealed a weekly body audit on 10/31/2020 with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 79	{M 615}		

wounds to right and left knee and left lower leg, with no measurements and the facility and was unable to provide any measurements. A body audit on 11/23/2020 with wounds right buttock with 2 open areas, with no measurements and were unable to provide any measurements. Resident #12 had no other weekly body audits completed until 05/07/2021. A weekly pressure injury record dated 04/19/2021 revealed a Stage 2 pressure wound to right buttock with measurements 0.3 cm x 0.3 cm x 0 cc, but the report was not signed. A weekly body audit done on 05/06/2021 signed by the DON revealed wound to left buttock with measurements 1.0 cm x 1.5 cm x 0.1 cm, wound to right buttock 2.0 cm x 0.5 cm x 0.1 cm and had listed right knee wound and left knee wound with no measurements, and DON could not provide any measurements for the wounds to the knees. Another weekly body audit was provided to the SA with wounds to right buttock with measurements 1.5 cm x 1.0 cm no depth, right knee (front), with measurements 1.0 cm x 2.0 cm no depth, and left knee (front) with measurements 3.5 cm x 3.0 cm granulated and no depth. The weekly body audit was signed by LPN #10. Another weekly body audit was given to SA with date 05/08/2021 and signed by the DON with measurements but did not list sites of wounds, or types of the wounds.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 80 Hypertension. Record review of the Quarterly Minimum Data Set (MDS) dated April 16, 2021 Section C revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 14, which means that Resident #12 is cognitively intact. Section H of the MDS revealed resident is always continent of bladder and frequently incontinent of bowel. Section M of the MDS revealed Resident #12 had one Stage 2 ulcer. Record review of Resident #12's care plans revealed no care plans for wounds. Record review of Resident #12's Physician Orders revealed orders for A and D ointment to buttock topically two times a day with Nystatin and triamcinolone with start date 04/14/2021, hydrogel apply to Stage 2 buttock topically two times a day for decubitus buttock with a start date 12/31/2021, and a new order on 05/10/2021 for zinc oxide apply to buttocks. Resident also had order to send to the local wound care clinic every 2 weeks with start date 03/16/2021. An order with start date 01/01/2021 noted clean bilateral knees with normal saline, pat dry apply Promogran to wound beds, secure with border gauze and changer every 48 hours, and another order with start date 04/20/2021 cleanse wound to left and right anterior knee with normal saline, pat dry, apply Silvadene to wound bed and cover with a border dressing one time a day for wound care. Record review of Resident #12's Proper Name local wound clinic wound report revealed date 04/08/2021 wound to right buttock Stage 2 pressure ulcer with measurements of 0.3 cm x 0.3 cm x 0.01 cm.	{M 615}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 81 Record review of Resident #12's RD progress note for 04/21/2021 revealed Stage 2 right buttock with recommendations add double protein portions all meals and add Juven twice a day x 14 days for wound healing. There were no orders noted on Physician Orders for Juven. Resident #13 Observation on 05/06/21 at 10:00 AM, revealed LPN #6 provide wound care to Resident #13's left heel. The nurse cleansed the left heel with wound cleanser, applied Santyl and covered with kerlix. The wound was open and pink in the middle of the wound bed. Record review for Resident #13's Face Sheet revealed the facility admitted Resident #13 initially on 04/04/2018 and readmitted on 11/30/2020 with diagnoses of Type 2 Diabetes Mellitus, High Blood Pressure, and Convulsions. The Face Sheet revealed Resident #13 was diagnosed with Pressure ulcer of left heel Stage 2 on 06/16/2021. Record review of Resident #13's Quarterly MDS with ARD date 04/28/2021 Section C revealed resident had a BIMS score of 02, which indicated severe cognitive impairment. Section M revealed Resident #13 had one Stage 2 pressure ulcer. Record review of Resident #13's Physician Orders revealed order for heel protectors bilaterally due to skin breakdown on left heel start date 12/31/2020, betadine solution apply to left heel topically one time a day for 14 days started on 01/01/2021 and then restarted on 01/22/2021 for 10 days and then again on 02/02/2021. A new order for Santyl Ointment apply to left heel and cover with gauze dressing one time a day for wound care start on 03/03/2021. An order to inspect resident feet daily started on 04/14/2021.	{M 615}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 82 Record review of weekly body audits for Resident #13 revealed resident had only one audit completed on 04/17/2021 with nothing listed and then a body audit on 05/08/2021 with description of pressure wound Stage 2 with eschar to left heel with measurements of length 5 cm and width 5 cm. A weekly skin report completed by DON dated 05/03/2021 revealed facility acquired wound left heel with measurement of 3.5 cm x 3.5 cm, which indicated wound had increased in size from 05/03/21 to 05/08/21. Resident #14 During an observation and interview on 5/6/2021 at 2:30 PM, SA observed the DON do a complete body audit on Resident #14. The body audit revealed an eschar area to left great toe healing. DON explained the area was an ulcer and she had been monitoring it, but it is getting better. The DON was observed measuring the wound with her index finger and thumb and charted 1 centimeter (cm) length and 2.5 cm width. She did not use any type of measuring instrument. The DON and SA observed scabbed area to Resident #14's left buttock with no dressing intact. The DON measured the area with her fingers again and recorded measurements of 2 cm length and 1 cm width. A hardened area noted to the left breast and the DON explained Resident #14 has breast cancer and area is being treated. No other skin issues were noted to Resident #14's skin. On 05/17/2021 at 11:00 AM, in a phone interview with the Responsible Party for Resident # 14, when asked had she been notified of any wounds for Resident #14, she explained no she had not. She further reported the facility usually is good about letting her know of any changes in the	{M 615}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 83	{M 615}		

resident but has not heard of any wounds the resident has or have had. She reports that she knows the resident is not very mobile and does sit a lot.

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 84	{M 615}		

started on 03/16/2021 for ensure hydrocolloid dressings are applied to left and right great toes as ordered, change dressings every 3 days and when visibility soiled as ordered date, initial, and time every dressing and document every dressing change in progress notes, and inspect resident's feet daily every shift, an order was started on 12/13/2021 for Hydrocol pad apply to left and right 1st toes ulcers topically every 72 hours, change dressings every 3 days and when visibility soiled and order discontinued on 04/09/2021 resolved.

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

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

Resident #17

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 85 how to work the wound vac for the resident. Observation on 5/10/21 at 2:50 PM, revealed the DON measured Resident #17's sacrum and right buttock. The wound to right buttock Stage 2 measured 4 cm x 3 cm x 0.1 cm, tissue pink/red with scant amount of bloody drainage noted. The Stage 4 Sacral Pressure Ulcer measured 12 cm x 10 cm x 4 cm with undermining at 9 and 12 o'clock. There was a moderate amount of serosanguinous drainage noted with a foul odor. The DON measured the wounds with a Q-Tip and then used a 4 x 4 gauze package for the measurements. Observation on 5/10/21 at 3:00 PM, revealed LPN #5 and LPN # 10 perform wound care on Resident #17's Sacral Pressure Ulcer and apply wound vac. A Stage 4 wound noted with a large amount of odorous, purulent drainage. Wound vac with suction noted after completion and setting as ordered. 05-10-21 at 3:30 PM in an interview with Resident #17, when asked how and when he got his wounds, Resident #17 explained he has had left sided weakness for years, could walk, and he fell at home. He explained after he fell, he could not walk as much and sat in his recliner. He explained his brother-in-law would come up and change him. He further explained he had diarrhea for 3 days and his buttocks became very red, and his brother-in-law took a picture. He reported his buttocks looked like it had blood pooled around it. He was taken to the Veterans Hospital in Louisiana and then the local hospital. He reported he was septic and almost died. He explained one of the hospitals had to do a scraping of the wound and he had to get a colostomy. He reported that he does not	{M 615}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 86	{M 615}		

remember giving consent for the colostomy, but he was so sick and took medications which made him more confused. He explained that his choices were to go to a nursing facility or go home with hospice. He reports he is starting to feel better now.

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

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

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On 5-13-21 at 9:30 AM, in an interview with Wound Care Clinic nurse, RN #2, When ask regarding Resident #17's wound care, she explained the wound care clinic has seen Resident #17 one (1) time on 4-29-21. She reported the clinic had a hard time getting his referral but got it straightened out. She reported the wound care clinic recommended the resident a wound vac and the Medical Nurse Practitioner works close with the wound care clinic and was to order the wound vac. She reported the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 87 next appointment is next Thursday 5-20-21. On 5-13-21 at 11:45 AM, in an interview with Medical Nurse Practitioner regarding wound care, she explained that wound care is not consistent in the building and that has become a problem with wounds. She explained the wounds will look good and then go bad. She explained the nurses do most of the wound care and the DON very seldom even looks at the wounds. She further explained the intravenous antibiotics are not given consistently either and she never knows if meds are given because the MARs are not signed. She reported that a nurse phoned her on Monday and explained to her the intravenous antibiotics were not available and a new order was given to give intramuscular. She further explained Am Pharm MSLLC consistently sends medication price reports and request medications to be changed due to the cost of the medications. When asked an example of what medication is denied she explained it has been antibiotic and wound care medications Santyl. She reported that she asks the DON, Administrator, and the admission lady who determined why we accepted Resident #17. The Nurse Practitioner explained she did not have any input on his admission and after he was admitted explained to the DON and Administrator the facility already had problems with wound care and Resident #17 required a lot of wound care with a wound like his and the facility is not capable to care for him. She reported he was admitted with osteomyelitis to his spine and requires more care. She explained the DON and Administrator explained to her the facility must get the census up and then the facility will be able to get a wound care nurse. Record review of Resident #17's Admission Record revealed the facility originally admitted	{M 615}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 88	{M 615}		

Resident #17 on 3/4/2021 and readmitted on 3/10/2021 with the Medical Diagnoses of Osteomyelitis of Vertebra, Sacral and Sacrococcygeal Region, Unstageable Pressure Ulcer of Sacral Region, Congestive Heart Failure, Diabetes Mellitus due to Underlying Condition with Foot Ulcer, Chronic Obstructive Pulmonary Disease, Chronic Peripheral Venous Insufficiency and Essential Hypertension.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 89	{M 615}		

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

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

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

Record reviewed of body audits and weekly pressure injury reports provided by the DON for Resident #17 revealed a Body Audit dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 90 05/06/2021 and could not determine measurements or exact locations for Resident #17. Another weekly body audit dated 05/08/2021 with three wounds listed and only one measurement for sacrum wound 12 cm x 10.4 cm x 4 cm with serosanguinous drainage, muscle and bones exposed, and undermining at 9 and 12 o'clock, with notes indicating new debridement to sacrum wound, resident refused measurements of groin denuded area, and resident refuses to turn to right and lays on back. Received weekly pressure injury reports for Resident #17 on 05/11/2021 with dates 3/4/2021, 3/15/2021, 4/7/21, and two reports for 5/8/21. The reports were all for Resident #17's sacrum wound and revealed wound measured 10 cm x 8 cm x 0.1 cm on 03/04/2021 and measured 12 cm x 10 cm x 4 cm on 05/08/2021. On 05/06/21 at 10:50 am interview with the DON, she explained she just started doing weekly wound care reports. She explained that she has not been consistent with doing wound reports. She explained the nurses on the med carts do the treatments and the measurements for each wound. When ask when the measurements are taken, she explained there is no special days to measure wounds. She reported no in services or special training regarding wound care has been done. She reported the only wound care training the nurses have had including her, are from school and she did wounds for Hospice before, but no wound care treatments were done in Hospice, she just kept the resident comfortable. She further explained that the nurse on the floor was to measure Resident #6's and Resident #3's wound today. SA explained the wound was not measured during wound care. On 5-6-21 at 1:00 PM in an interview with LPN	{M 615}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 91 #5, when ask about measuring wounds, she explained she has never measured any wounds including Resident #7. She further explained the DON ask her to measure wounds and she feels that the DON needs to look at the resident's wounds at least weekly. She explained the DON ask for our measurements for her report, but the DON does not look at wounds weekly and does not measure wounds. On 5/6/21 at 1:00PM, in an interview with the Minimum Data Set (MDS) nurse, she explained that she in getting wound reports from the DON. he has tried to get information from the DON regarding wounds but has not been able to get any reports. She explained that every morning during the facility's stand -up meeting she ask for wounds and the DON said she has the reports but has never produced anything. She explained she obtained the information by going through the nurse and nurse practitioner notes. When asked if the facility has a system in place to check assessments prior to submitting the report, she reports since she has worked at the facility doing MDS assessments, she submits the assessments and then she lets the Corporate Office know when the assessments have been submitted. On 5-6-21 at 1:30 PM in an interview with CNA #4, she explained she is the lead CNA, and does some in-services with the CNAs. When ask her regarding in-services with CNAs for skin changes with the residents, she explained the DON does in-services on the wounds and skins and she does not remember when the last one was done. 5-6-21 at 5:00 PM in an interview with Registered Dietician when ask regarding wounds, she explained she does consults and record review	{M 615}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 92	{M 615}		

for residents with wounds greater than a Stage 2 and will see residents with weight loss. She explained the resident she seen last month with wounds include Resident #3, Resident 7, Resident #12, and Resident #17.

5-6-21 at 5:30 PM in an interview with the Nurse Consultant, she explained the DON has not been consistent with wound care reports for months. She explained she has gone over the wound care with the DON and explained to the DON that she would need to assess the wounds weekly and would discuss the wounds weekly. She explained she has not been able to do patient at risk (PAR) notes due to no wound reports turned in. She further reported that about one (1) or two (2) months ago she asks the DON to do complete 100% body audits in the building but never received the audits. She explained she had been working as acting DON at a sister facility and not been able to follow-up on body audits. Explained to the Nurse Consultant that the SA has asked for weekly wound reports and only received one report with the date of 5-3-21 and other notes from the DON with names and measurements listed but no dates. The Nurse Consultant reported that the wounds are to be assessed on admission and weekly.
5-7-21 10:00 AM In an interview with DON, ask her how she measured the wounds yesterday with the body audits, she demonstrated with her thumb and index finger. She reported she measured with her fingers. She further explained that she has looked at wounds so much that she knows the measurements. When ask the appropriate way to measure wounds, she explained with a ruler. She further explained she needs a little measuring tape and that she never knew how to measure with the circle measuring tool. She reported she likes to use a gauze with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 93	{M 615}		

the wrapper to measure the wounds. She explained that she must send reports to America Health Technologies (AMT) who provides supplies, the facility Nurse Consultant, and the Dietician but again she explained she has been overwhelmed with the DON position and has not been consistent with would care reports.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 615}	Continued From page 94	{M 615}		

schedule wound measuring for Monday because she must have the weekly wound reports turned in to the nurse consultant on Thursday.

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

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

On 05-10-21 at 10:20 AM in an interview with the DON to review body audits with DON which she done last week and over the weekend, she explained she included all findings on the individual body audit sheets, and she measured all wounds and printed a non-pressure and pressure wound report. She explained wounds on Resident #14's coccyx wound, scab was gone and healed. She explained that Resident #12's wounds on his left buttock healed and one on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 95 right buttock healed but she assessed wounds as shear tears. DON questioned Corporative Consultant and Nurse Consultant if a gluteal fold wound is pressure, both replied it would depend on what it looked like and where it is. DON reported that she does not think it is a pressure wound. Reviewed report for Resident #7 with DON and Resident #7 only having one wound listed, she explained she is not sure maybe the wound on the right hip was healed. On 05/20/21 at 12:30 AM in an interview with local Medical Doctor (MD) report she has concerns related to the facility does not complete appropriate wound assessments. The wound assessments are not done for several weeks at a time. The MD stated the Director of Nursing (DON) changes the wound care orders without permission because of the cost of the medication. The MD stated she has not been invited to the QAPI meetings because (proper name) is still the Medical Director. The MD stated she has met with the Administrator and DON about her concerns. Removal Plan: The deficient practice consisted of failure to ensure residents received care, consistent to prevent pressure ulcers, to promote the healing of pressure ulcers, prevent an infection, and prevent new ulcers from developing. Noncompliance at F686 has affected Residents #3, #5, #6, #7, #12, #13, #14, and #17. The Certified Wound Care Nurse and MDS Coordinator assessed wounds for staging and treatment on 5/28/21 for Residents #3, #5, 6#, #7, #12, #13, #14, and #17 to ensure correct treatments are being provided and interventions are appropriate for the wounds identified. Any necessary changes to treatment and medications	{M 615}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 96 were reported to the Medical Director. Any physicians' orders were entered at that time and the care plans updated. Residents #4, #8, #9, #10, #11, #15, & #16 Care Plans were assessed and updated with correct staging, treatment, and interventions. In addition: On 5/22/21, the Charge Nurses, MDS Coordinator, and DON were provided an in-service to educate them regarding the failure to assess wounds weekly and to change, develop, or update the resident's care plan immediately when wounds change. CNA competency training--including toileting techniques, turning, and positioning were completed by 6/1/21 by the Lead CNA. On 6/03/21, Corporate Management approved for Wound Care Specialists from other facilities to work in the Facility to assist with audits of wounds, wound care, training, and assist with correcting care plans. All Residents listed have been thoroughly assessed & reassessed regarding the wound care provided to them in the Facility. Care plans have been updated, and education has been provided to all staff regarding: measurements, Braden scale frequency, notification of families about new wounds and status of wounds, and documentation of care provided. Beginning 5/6/21, all other residents' care plans were evaluated for behaviors and wounds, and a comprehensive plan of care was completed for each resident. The Care Plan Committee implemented comprehensive care plans for Residents #2, 3, 6, 7, 9, 10, 11, 14, 15, 17, 20, 30, and 31 on 5/21/2021 related to wounds and medications. Resident # 4 discharged on 1/29/20, Resident 5 discharged on 1/21/21, and Resident #12 discharged on 5/17/21.	{M 615}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 97 The Regional Nurse Consultant contacted American Medical Technologies (AMT) to request an in-service for nursing staff related to skin and wounds on 5/21/21. AMT completed an evaluation of Facility residents' wounds on 6/4/2021 for any necessary additional changes. The Nurse Practitioner was scheduled to attend a training and education with AMT on 6/4/21 to gain knowledge regarding assessing and staging wounds and the clarification of appropriate wound treatment orders. The Assistant Director of Nursing completed skills competencies with the Regional Nurse Consultant on 5/21/2021 that included routine competencies, skin and wound, behavioral health, and medication administration. On 5/22/21, the Regional Nurse Consultant conducted education for the Director of Nursing, ADON/ICC, and Medical Records Nurse regarding monitoring care plans, medication administration, wound care, pharmacy services, and communication with Governing Body. Licensed nursing staff completed body audits on all patients on 5/23/2021, any new skin concerns were addressed at that time. The wound care-certified Regional Nurse Consultant educated the Director of Nursing regarding the skin and wound care process including prevention, identification, treatment, documentation, wound vacs, and tracking and reporting wounds on 5/23/2021. The Regional Nurse Consultant and ADON/ICC began on 5/27/21 and completed on 5/29/21 a review of all residents' care plans for skin issues, therapeutic medications on their care plans, and any behaviors noted to ensure that the care plans are current and up to date. Validation: The State Survey Agency (SSA) validated through interviews with the Certified Wound Care Nurse	{M 615}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 615}	Continued From page 98	{M 615}		

and MDS Coordinator and review of pressure wound reports, body audits, and care plans, the Certified Wound Care Nurse assessed wounds for staging and treatment for Residents #3, #5, # 6, #7, #12, #13, #14, and #17 to ensure correct treatment and interventions were appropriate for wounds identified and any changes were reported to the Medical Director and care plans were updated as needed.
The SSA validated through review of pressure wound reports, body audits, care plans and interviews with Certified Wound Care Nurse and MDS Coordinator, Residents #4, #8, #10, #11, #15, and #16 were assessed, new skin issues were identified, and all orders and care plans were updated with correct staging, treatment, and interventions.
The SSA validated through record review and interviews the Comprehensive Care Plan for Resident #3 was updated to include the wound care clinic appointments, correct staging and current wound care orders for sacrum wound by the MDS Coordinator and Wound Care Nurse Specialist.
The SSA validated through record review and interview Resident #5 was discharged from the facility on 1/21/21.
The SSA validated through review of the Comprehensive Care plan and interview with the MDS Coordinator, Resident #6's care plan was revised to include wounds.
The SSA validated through record review of the Pressure Wound Assessment, the Comprehensive Care Plan, and interviews with the Certified Wound Care Nurse and the MDS Coordinator, Resident #7 was assessed for wounds and the MDS Coordinator updated the care plan with the correct number of wounds and treatment.
The SSA validated through record review of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 99	{M 615}		

Pressure Wound Assessment, the Comprehensive Care Plan, and interviews with the Certified Wound Care Nurse and the MDS Coordinator, Resident #13 was assessed for wounds and the MDS Coordinator updated the care plan to include wounds.
The SSA validated through record review of the Pressure Wound Assessment, the Comprehensive Care Plan, and interviews with the Wound Care Nurse Specialist and MDS Coordinator, Resident #14 was assessed for wounds and the MDS Coordinator updated the care plan to include the treatment and intervention to the Stage 2 on the Buttocks.
The SSA validated through record review of the Pressure Wound Assessment, the Comprehensive Care Plan, and interviews with the Certified Wound Care Nurse and the MDS Coordinator, Resident #17 was assessed for wounds and the MDS Coordinator updated the care plan to include the correct staging of the wound on the left heel.
The SSA validated through interviews and review of In-Service sign sheet including content of in-services that Charge Nurses, MDS Coordinator, and Director of Nursing (DON) were in-serviced regarding the failure to assess wounds weekly and to change, develop, or update the resident's care plans when there is a wound change.
The SSA validated through interviews and review of the competency training list competency training was completed by the Lead Certified Nursing Assistant (CNA) for CNA,s including toileting techniques, turning, and positioning of residents.
The SSA validated through interview with the Wound Care Specialists from another facility that he is currently on site at the facility to assist with audits of wounds, wound care, training, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 100	{M 615}		

correcting care plans until a person that is Wound Care Certified is hired.
The SSA validated through interviews with the Certified Wound Care Nurse and MDS Coordinator and review of pressure wound reports, body audits, care plans, and Inservice Sign-in sheets, the Certified Wound Care Nurse has assessed wounds for Residents #3, #5, # 6, #7, #12, #13, #14, and #17 and provided education to all nursing staff regarding wound measurements, Braden scale frequency, notification of families about new wounds and status of wounds, and documentation of wound care provided.
The SSA validated through review of an audit form completed by the ADON, MDS Coordinator, and Regional Nurse all Residents care plans were evaluated for behaviors and wounds and a comprehensive care plan completed as needed. Residents #2, #9, #20, #30, and #31 were identified through the audit as requiring a care plan for wounds and medications.
The SSA validated through review of the Comprehensive Care Plans, care plans were implemented for Residents #2, #3, #6, #7, #9, #10, #11, #14, #15, #17, #20, #30, and #31 to include wounds and medications.
The SSA validated through review of an in-service sign-in sheet a contracted consultant conducted an in-service for nursing staff and the nurse practitioner regarding wound care, wound prevention, assessing and staging wounds, and clarification of appropriate wound treatment orders. The SSA validated through an interview with a contracted consultant an assessment of the facility's wounds and care was completed by the contracted consultant as a tool to assist in the in-services.
The SSA validated through interview and record review of competency skills check off, the ADON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 615}	Continued From page 101 completed skills competencies with Regional Nurse Consultant that included routine competencies basic review for nurses, dressing change, and skin and wound care. The SSA validated through interviews and record review of In-Service sign in sheets, the Regional Nurse Consultant provided education for the DON, ADON, and Medical Records Nurse regarding care plans, wound care, and communication with the Governing Body. The SSA validated through review of body audit forms that audits were completed on all patients by licensed nurses. The SSA validated through record review of the In-Service sign in sheet, the Regional Nurse Consultant conducted a bundle in-service with DON regarding skin and wound care process including prevention, identification, treatment, documentation, wound vacuums, and tracking and reporting wounds. The SSA validated through review of an audit form completed by the Regional Nurse Consultant and ADON/ICC, care plans were reviewed for skin issues, therapeutic medications and behaviors for all residents to ensure care plans are current.	{M 615}		
{M 630}	45.21.6 Mental and psycho-social Mental and psycho-social. A resident who displays adjustment difficulty receives appropriate treatment and services to address the assessed problem. This Statute is not met as evidenced by: Based on observation, interviews, record review, facility policy review, hospital discharge recommendations, the facility failed to provide Behavioral Health services when a resident was	{M 630}	1. Resident #6 was evaluated by the Social Services Director on 4/20/2021 for any psychosocial needs and evaluated again by the Psychiatric Nurse Practitioner	7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 630}	Continued From page 102 assaulted, and hair pulled by Resident #1 for one (1) of five (5) residents reviewed for behaviors, Resident #1. The failure to provide Behavioral Health Services and address known behaviors put Resident #6 and all other residents who reside in the facility at risk for serious harm, serious injury, serious impairment, or death. Resident #1 was witnessed with aggressive behaviors including yelling, cursing, threatening, and physically touching other residents. This situation was determined to be an Immediate Jeopardy (IJ), which began on 3/17/21 and determined to exist on 4/20/21. The IJ was not removed prior to exit on 5/26/21 and was considered ongoing. The IJ and Substandard Quality of Care (SQC) existed at M630-Mental and Psycho-social The IJ was not removed prior to the State Agency (SA) exit on 5/26/2021 and was considered ongoing The facility provided a Credible of Removal Plan of IJ, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit in order to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interview, resident interview, family interview, record review, in-service review, and observation. The facility provided evidence the facility had implemented corrective actions listed	{M 630}	on 5/07/21. The resident received Pastoral Consultation on 5/25/21. Resident #1 was sent out and admitted to behavioral health on 4/21 and again on 5/4/21. The resident was discharged to behavioral health on 05/07/21. The Psychiatric Nurse Practitioner visited residents with dementia and known behaviors on 5/10/2021 and evaluated their status and treatment plans. Psychiatric Nurse Practitioner will follow these Resident□s weekly, as needed. Physician #1 was verbally educated on the necessity of Psychiatric Services for patients with known behaviors by Administrator on 5/25/2021. Patients with behaviors were reviewed on 5/6/2021 by the Social Services Director to ensure appropriate interventions for behaviors were in place. This was ongoing until completed on 5/26/21. On 5/7/21, the Psychiatric Nurse Practitioner assessed residents for psychosocial concerns in relation to the aggressive behaviors of Resident #1, as well as those residents with documented behaviors. No new orders were given. Beginning 5/6/21 all residents were evaluated for behaviors by the Nurse Management Team (Director of Nursing, Minimum Data Set, Assistant Director of Nursing/Infection Control Coordinator, Medical Records) and a comprehensive plan of care was completed for each resident. 2. All residents with behaviors have the potential to be affected by the deficit practice cited. 3. Beginning 5/6/21, the Senior Director of Operation, Administrator and/or Assistant Director of Nursing/Infection	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 630}	Continued From page 103 in the Credible Allegation of Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for M630 has been lowered from the severity of a Level IV to the severity of a Level II. The facility will remain out of compliance at the Severity of Level II that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: The facility's, "Behavioral Health Services" policy, undated, noted, it is the policy of the facility to provide all residents the necessary behavioral health care and services to assist him or her to reach and maintain the highest practicable level of physical, mental, and psychosocial functioning in accordance with the comprehensive assessment and plan of care. This policy noted behavioral health care plans will be reviewed and revised as needed, such as when interventions are not effective or when the resident experiences a change in condition. A review of the facility's last Dementia training, dated January 21, 2020, revealed the facility had conducted a virtual training with the facility staff. Resident #1 A review of Resident #1 Pre-Admission Screening (PASSR) dated 3/30/21, revealed Resident #1 has a diagnosis of Alzheimer's Dementia. The	{M 630}	Control Coordinator conducted multiple mandatory in-services with all nurses (Registered Nurse, Licensed Practical Nurse, Certified Nurse Aides) and facility employees including regarding behavioral health care, aggressive behaviors, symptoms of acute mental status change, acute behavior changes, and behavior assessment plan and forms. These in-services were either in-person, in a classroom setting, or 1:1, either in person or by telephone. Any staff missing in-services will not work until they receive the education. Any staff who fail to comply with the directions of the in-services will be further educated and/or progressive discipline will begin as indicated. No staff will be allowed to work until mandatory in-services are completed. Beginning on 05/20/21 and completed on 05/23/21, Human Resources initiated for all staff the six modules of Hand in Hand training that include four modules on Dementia/Behaviors and two modules on abuse and neglect. Direct care staff were in-serviced by the Social Services Director and Life Connections Coordinator on 5/24/2021 to include behavior management techniques, notifying the interdisciplinary team of behavior concerns, providing safety for residents in the event of behaviors, and de-escalation techniques. On 5/28/21, Second Wind Dreams completed virtual dementia training with all nursing staff. Beginning on 5/29/21 and completed on 6/01/21 the Director of Operations reviewed the facility□'s behavior management program policy for needed updates with no recommendations for change. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 630}	Continued From page 104 PASSR revealed Resident #1 takes and has a history of taking, psychotropic medication, but the PASSR does not have a diagnosis or history of a major mental illness listed for Resident #1. A review of the facility's Comprehensive Care Plan dated 4/15/21, revealed Resident #1's care plan listed the resident "has the potential to be aggressive with staff and other residents related to anger, dementia, and poor impulse control" due to impaired cognitive function/dementia or impaired thought process related to Dementia or impaired thought processes r/t Dementia. The interventions included to engage the resident in simple, structured activities that avoid overly demanding tasks, to administer medications, analyze time of day, places, circumstances, assess, anticipate the resident's needs, triggers and what de-escalates behavior, to cue, reorient and supervise as needed. Resident #1 also has Activities of Daily Living (ADL) self-care performance deficit related to aggressive behavior and confusion. A review of the previous facility's progress notes dated 3/8/21 revealed Resident #1 exhibited behaviors prior to admission. Resident #1 continues to wander, requires constant monitoring and redirection by staff, sometimes resident is verbally aggressive with staff and residents, spits on the floor and going in and out of other residents' rooms. A review of the facility's Nurses' Notes dated 4/20/21 at 11:06 AM, revealed Registered Nurse (RN) #2 over heard Resident #6 say "don't touch my hair." The note revealed RN #2 got up from the nurse's station to see what was going on. RN #2 heard Resident #1 say "I'm going to kill your God D**n A**." Resident #1 repeated that two	{M 630}	Psychiatric Nurse Practitioner will continue to monitor those residents for potential psychosocial concerns in relation to Resident #1, and to monitor residents with documented behaviors and those residents receiving psychoactive meds. 4. The Director of Social Services for the management company, facility Social Services or Life Connections Coordinator will review progress notes for new behaviors daily times three months beginning 6/21/21. Three residents will be selected to ensure appropriate interventions and updated care plans weekly times four weeks beginning 6/21/21 and monthly times three months beginning 7/21/21. Findings will be brought to QAPI monthly beginning 7/2/21 for review, revision, or resolution of the plan for six months. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance. The Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 630}	Continued From page 105 more times. Observation 5/4/21 at 1:14 PM, revealed Resident #1 pacing up and down the facility hallway screaming and cursing loud with balled fist. Resident #1 did not have on shoes or mask. The facility Administrator attempted to redirect the resident and was unsuccessful. Resident #1 approached the State Agency (SA) and poked her in the chest. The resident was redirected by the staff down hallway. On 05/5/2021 at 2:00 PM, in an interview with Resident #6, revealed she is afraid of Resident #1. Resident #6 said Resident #1 pulled her hair and hit her. Resident #6 said Resident #1 yells and screams at the other residents and staff all day. During an interview on 05/5/21 at 1:15 pm, with the Director of Nurses (DON) revealed she do not have any behavioral health training. The DON said she was not part of the admission process when Resident #1 was admitted to the facility. The DON said the residents and the staff are afraid of Resident #1. The DON confirmed the staff has not had any behavioral health training. The DON said Resident #1 is a danger to himself and others. The DON said the staff told her Resident #1 pulled Resident #6's hair and verbally threatened her. The Doctor wrote orders to send him to the local Behavioral Unit. A review of the local Behavioral Health notes dated 4/20/21, revealed Resident #1 was admitted 4/20/21 due to aggressive behaviors. Resident #1 presented with psychosis, hallucinations, and aggressive behaviors toward other Residents at the nursing home. Resident #1 continues to pace in the hallways at the nursing	{M 630}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 630}	Continued From page 106	{M 630}		

home. Resident continued to present with aggression/threatening behavior, medication was given to stabilize him.

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

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

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

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

On 5/5/22 at 10:15 AM, with (RN) #3 said she was sitting at the nurse station on the Alzheimer's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 630}	Continued From page 107	{M 630}		

Unit (AD) and heard Resident #6 say "do not touch my hair again". The nurse said she did not see Resident #1 hit Resident #6. The nurse said by the time she got down the hall Resident #1 was yelling and threatening Resident #6. Resident #1 said I am going to kill you, "B****." The nurse said she separated the residents. RN #3 said she has asked the DON and the Administrator several times to send Resident #1 out. The nurse said Resident #1 is dangerous and she is afraid he is going to hurt one of the residents or the staff. RN #3 said Resident #1 is hard to redirect.

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

On 5/5/21 at 10:45 AM, in an interview with The Activity Coordinator (AC) for the AD unit said she was responsible for doing Dementia training with the staff. The (AC) said the staff is trained on hire and annually. The AC said the staff has not been trained in over a year since the pandemic began. The facility has hired several new staff that has not been trained on Dementia care. The AC said when Resident #1 was on the AD unit she had to do one on one activities with him because his attention span was short. The AC coordinator said he was hard to redirect. He would yell and scream at the other residents.

An interview on 5/5/21 at 11:30 AM, with CNA # #7 said he works the 7-3 shift. CNA #7 said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 630}	Continued From page 108 Resident #1 is hard to redirect. CNA #7 said Resident #1 fights the staff when they attempt to provide care. CNA #7 confirmed he has not had any behavior training on how to take care of residents with those type of behaviors. The resident is frightening and intimidates the other residents. During an interview on 5/5/21 at 1:30 PM, with the Psych Nurse Practitioner (NP) revealed she has not been in the facility since March 2020. The Psych (NP) said the facility refused to allow her to come in the facility due to Covid-19. The facility called her and asked her to come back to the facility on 05/5/21. The Psych (NP) said she will assess and monitor the residents on the AD and the residents that have behaviors. The Psych (NP) said she monitors the residents' medications. The Psych (NP) said she will be visiting the residents twice a week. The Psych (NP) said she will review all Residents that is on psychotropic medications at that time. On 5/11/21 at 4:35 PM, in an interview with License Practical Nurse (LPN) #14, revealed she worked the AD unit with Resident #1. LPN #4 said Resident #1 cursed the staff and other residents all the time. LPN #14 said Resident #1 continued to call them "B*****s and M****r F*****s" the whole shift. LPN #14 also said Resident #1 is hard to redirect and is impulsive. He runs up to the other resident's faces and draws his fist, yells, and curses at them. LPN #14 confirmed she has not had any behavior or dementia training. LPN #14 said she did not know what to do for Resident #1. LPN #14 said she reported to the DON and the Administrator that the staff did not know what to do to take care of Resident #1 and that he was a danger to himself and the other residents. LPN #14 said she was told to call the doctor and report	{M 630}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 630}	Continued From page 109	{M 630}		

his behavior. LPN #14 said she was calling the doctor every hour and the doctor finally said do not call her again, call the Administrator because he refuses to send the resident to a behavioral health unit. LPN #14 said the Administrator said he could not send the resident out because his census was low, and he had to keep every resident he could in the building. LPN #14 said she told the Administrator that it is not right that the facility will not get this man some help and cause the other residents to be in fear in their home. LPN #14 said this is the most horrible place, "I've ever worked."

Record review of the Face Sheet revealed the facility admitted Resident #1 on 3/17/2021, per the face sheet, with the diagnoses that included Dementia with Behavioral disturbance, Epilepsy, Mood disorder and Psychosis. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/26/21, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) of 00 indicating Resident #1 is cognitively severely impaired.

Removal Plan:
Resident #6 was evaluated by the Social Services Director on 4/20/2021 for any psychosocial needs and evaluated again by the Psychiatric Nurse Practitioner on 5/07/21. The resident received Pastoral Consultation on 5/25/21.
Resident #1 was sent out and admitted to behavioral health on 4/21 and again on 5/4/21. The resident was discharged to behavioral health on 05/07/21.
Beginning 5/6/21, the Senior Director of Operation, Administrator and/or ADON/ICC conducted multiple mandatory in-services with all nurses (RN, LPN, CNAs) and facility employees including regarding behavioral health care,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 630}	Continued From page 110	{M 630}		

aggressive behaviors, symptoms of acute mental status change, acute behavior changes, and behavior assessment plan and forms. These in-services were either in-person, in a classroom setting, or 1:1, either in person or by telephone. Any staff missing in-services will not work until they receive the education. Any staff who fail to comply with the directions of the in-services will be further educated and/or progressive discipline will begin as indicated. No staff will be allowed to work until mandatory in-services are completed.
The Psychiatric Nurse Practitioner visited residents with dementia and known behaviors on 5/10/2021 and evaluated their status and treatment plans. Psychiatric Nurse Practitioner will follow these Resident's weekly, as needed.
Beginning on 05/20/21 and completed on 05/23/21, Human Resources initiated for all staff the six modules of Hand in Hand training that include four modules on Dementia/Behaviors and two modules on abuse and neglect.
Direct care staff were in-serviced by the Social Services Director and Life Connections Coordinator on 5/24/2021 to include behavior management techniques, notifying the interdisciplinary team of behavior concerns, providing safety for residents in the event of behaviors, and de-escalation techniques.
Physician #1 was verbally educated on the necessity of Psychiatric Services for patients with known behaviors by Administrator on 5/25/2021.
On 5/28/21, Second Wind Dreams completed virtual dementia training with all nursing staff.
Patients with behaviors were reviewed on 5/6/2021 by the Social Services Director to ensure appropriate interventions for behaviors were in place.
Beginning 5/6/21 all residents were evaluated for behaviors by the Nurse Management Team (DON, MDS, ADON/ICC, Medical Records) and a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 630}	Continued From page 111	{M 630}		

comprehensive plan of care was completed for each resident. This was ongoing until completed on 5/26/21.
On 5/7/21, the Psychiatric Nurse Practitioner assessed residents for psychosocial concerns in relation to the aggressive behaviors of Resident #1, as well as those residents with documented behaviors. No new orders were given. The Psychiatric Nurse Practitioner will continue to monitor those residents for potential psychosocial concerns in relation to Resident #1, and to monitor residents with documented. behaviors and those residents receiving psychoactive meds.
Validation:

The State Survey Agency (SSA) validated through review of the facility Progress notes Resident #6 was evaluated by the social services director on 4/20/21 for psychosocial needs and evaluated by the Psych NP on 5/7/21 Resident #6 received a pastoral consultation on 5/25/21.
The SSA validated through review of the facility progress notes Resident #1 was discharged from facility to behavioral health facility on 5/7/21.
The SSA validated through staff interviews and review of in-service sign in sheets, the Senior Director of Operations, Administrator, and ADON/ICC conducted multiple mandatory in-services with all nursing disciplines (RN, LPN, CNA's) and facility employees including regarding behavioral health care, aggressive behaviors, symptom of acute behavior changes, and behavior assessment plans and forms. Any staff who failed to comply with the directions of in-services will be further educated and or progressive discipline will begin as indicated. No staff will be allowed to work until mandatory in-services are completed. The ADON verified no staff had worked until they received in-services and there have been no staff who have failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 630}	Continued From page 112	{M 630}		

comply with the directions of the in-services.
The SSA validated through interviews and review of Progress notes the psychiatric NP assessed residents with dementia and known behaviors on 5/10/21 and evaluated their status and treatment plans. The psych NP will follow these resident's weekly as needed.
The SSA validated through interviews and review of the facility in-service sign in sheets, on 5/20/21 and completed on 5/23/21, Human resources initiated for all staff the six modules of hand training that include four modules on Dementia/ behaviors and two modules on abuse and neglect.
The SSSA validated through staff interviews and review of in- service sign in sheets, the Social Services Director (SSD) and Life Connections Coordinator conducted in-services regarding behavior management techniques, notifying the interdisciplinary team of behavior concerns, providing safety for residents in the event of behaviors, and de-escalation techniques.
The SSA validated through interviews and record review Physician #1 was verbally educated on the necessity of psychiatric services for patients with known behaviors by the Administrator on 5/25/21.
The SSA validated through review of facility in-service sign in sheets, virtual dementia training with all nursing staff was conducted by a contracted training provider on 5/28/21.
The SSA validated through interviews and review of the Comprehensive Care Plans and progress notes, the SSD reviewed the care plan interventions for residents with behaviors and made changes as needed.
The SSA validated through interviews and review of the progress notes all residents were reviewed by the nurse management team (DON, MDS, ADON/ICC Medical Record) and care plans were completed for each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 630}	Continued From page 113 The SSA validated through interviews and review of progress notes and the facility policy on 5/7/21 the psychiatric NP assessed residents for psychosocial concerns in relation to the aggressive behaviors of Resident #1 as well as those with documented behaviors. The consultant reviewed the behavior management program policy with no needed changes on 6/1/21.	{M 630}		
{M 700}	45.24.1 General General. The facility shall provide routine drugs, emergency drugs and biologicals to its residents or obtain them by agreement. This Statute is not met as evidenced by: Level IV Based on observation, staff and resident interview, facility policy review and record review the facility failed to ensure that routine medications were acquired and administered to meet the needs of the residents. Facility documentation indicated that 12 of the 17 residents had missed 393 doses of significant medications. (Resident #1, #2, #4, #7, #8, #9, #10, #11, #12, #15, #16, and #17) The Facility's failure to provide routine medications placed residents at risk, and in a situation that resulted in hospitalization of Resident #4 and likely resulted in the death of Resident #12 who expired in the facility after missing 37 doses of significant medications. Missing significant medications is likely to cause serious harm, injury, impairment of death to all residents residing in the Facility. This situation was determined to be an	{M 700}	1. The Assistant Director of Nursing/Infection Control Coordinator (ADON/ICC) was in-serviced regarding the process of obtaining medications from the pharmacy, including the back-up pharmacy process, on 5/22/2021 by the Regional Nurse Consultant. The ADON/ICC initiated education on obtaining medications from the pharmacy, the back-up pharmacy process, and completing match backs daily for all nurses on 5/22/2021. The Medical Record□s Manager, Assistant Director of Nursing/ICC, and the Director of Nursing(DON) completed a match back for Residents #2, #7, #8, #9, #10, #11, #15, and #17 on 5/21/21 to ensure that all medications were available as ordered. Any medications noted as unavailable were ordered from the pharmacy and were obtained on 5/22/21. The attending physician was notified of the missed medications on 5/25/2021 by Medical	7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 114 Immediate Jeopardy (IJ) which began on 11/17/2020, when Resident #4 missed 26 doses of medications ordered for COVID-19, was hospitalized on 11/29/2020 and subsequently died at home. There were also eleven (11) other residents who missed significant medication doses. The facility Administrator was notified of the IJ on 5/21/2021 and the IJ template was given to the Administrator at 3:30 PM. The IJ and Substandard Quality of Care (SQC) existed at M700- Pharmacy Services General. The IJ was not removed prior to the State Agency (SA) exit on 5/26/2021 and was considered ongoing. The facility provided a Credible Removal Plan, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interviews and in-service sign-in sheets review. The facility provided evidence the facility had implemented corrective actions listed in the Credible Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for M700 has been lowered from the severity of a Level IV to the severity of a Level II. The facility will remain out of compliance at the Severity of Level II that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and while the facility's Quality Assessment and	{M 700}	Records with no new orders at that time Residents #2, #7, #8, #9, #10, #11, #15, and #17. Residents #1, #4, #12, and #16 are discharged; the Facility was unable to evaluate the residents that were discharged for impact. On 6/01/21, the Owner sent a letter of termination of services to the current Pharmacy Service; a new company will take over in 30 days. There will be no lapse in coverage. 2. All residents receiving medication have the potential to be affected by the deficit practice cited. 3. Beginning 5/24/2021 through 6/12/21, the ADON/ICC, Minimum Data Set Coordinator, and Regional Nurse Consultant conducted multiple in-services with nursing employees (Registered Nurses, Licensed Practical Nurses) regarding documentation of medication, specifically omission or not documented medications. Any staff missing in-services will not work until they receive the education. Any staff member who fails to comply with the direction of the in-services will be further educated and/or progressively disciplined. Daily medication match backs were initiated on 5/21/21 by the medication nurses to ensure that medications were obtained timely for residents to receive their medications. The Medical Record□s Manager, Assistant Director of Nursing and the Director of Nursing completed a match back on 5/21/21 of all medication carts to ensure that all medications were available as ordered. Any medications noted as unavailable were ordered from the pharmacy. 4. DON or ADON will utilize the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 115 Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the Facility's policy entitled "Pharmaceutical Services", dated February 26, 2003, reveals that it is the policy of the Facility to provide all drugs and biologicals an approved pharmaceutical service and such services are under the supervision of a Registered Pharmacist. The Procedure states: "1. Pharmaceutical services are available to ensure that our resident's drugs and biologicals are provided as ordered by the attending physician ... 3. Our pharmaceutical services provide appropriate methods and procedures for the procurement, dispensing and administration of drugs and biologicals. 4. Pharmacy service, including the availability of obtaining prescription drugs, is provided on a twenty-four (24) hour basis. 5. Pharmacy services are monitored to assure that our drug distribution system, to include the ordering, labeling, and administering of drugs and biologicals, is in compliance with out established policies and procedures ....." Review of the facility's policy entitled "AmPharm Backup Information", undated, revealed: ..... "2. The facility can get up to 3 days of medications to cover until our shipment reached the facility. Getting more than a 3-day supply is not authorized. 3. If medications are needed for a patient during our hours of operation, the facility is to contact AmPharm, and we will take care of the backup process. 4. If medications are needed for a patient during hours that AmPharm is closed,	{M 700}	medication audit tool to monitor non-administered medication weekly times four weeks beginning 7/1/21 and monthly time three months beginning 8/1/21. New orders and non-administered meds are reviewed daily in clinical standup beginning 6/21/21. Med Pass audits will be performed by the DON or ADON using the CMS med pass audit tool weekly times four weeks beginning 6/21/21 and monthly times three months beginning 7/21/21. Findings will be brought to Quality Assurance Performance Improvement monthly beginning 7/2/21 for review, revision, or resolution of the plan. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance and will continue for 3 months or as needed. The Administrator will report to the Governing Body and Management Company the monitoring outcomes on a monthly basis beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 116 the facility is to contact the after-hours pharmacy and they will take care of getting the medications filled and delivered to the facility. The facilities are not authorized to contact backup directly for medication fills. They are to contact AmPharm or the after-hours pharmacy. This is to keep costs down and to have a record of medications we need to send without duplicating items." On 5/5/21 at 9:10 AM, in an observation and interview of medication pass with Licensed Practical Nurse (LPN) #6, two (2) medications were unavailable for administration. Resident #8 did not receive Jardiance 25 MG ordered for Diabetes and Topiramate 25 milligrams (MG) ordered for the prevention of headaches. LPN #6 entered a number "9" in the signature box and stated the nurses record that number in the resident's record to identify that the medications were not administered because they are unavailable. She further stated that there is no back up pharmacy and that the facility has an emergency kit for medications, but it contains mostly antibiotics. On 5/6/2021 at 8:10 AM, an interview with LPN #5, she stated that medications are not always available on the medication cart, as they are on order. On 5/6/21 at 10:45 AM, in an interview with the Director of Nurses (DON), she explained that the Facility uses a Local Pharmacy (LP) for back up. She stated that if medications are needed, the nurses must contact the Facility's Pharmacy (FP) and they contact the back-up pharmacy. She stated that Human Resources provides orientation to newly hired nurses on ordering medications.	{M 700}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 117 On 5/6/2021 at 2:30 PM, an interview with LPN #9, she stated that she has worked at the facility for three (3) months. She stated the facility only uses the FP, but they used to use the LP for back-up meds. On 5/6/2021 at 3:55 PM, in an interview with the Medical Nurse Practitioner (MNP), she stated that residents have told her they have not been receiving their medications. When residents have complained, she would question the nurses about the medications, and they would tell her that the medications were on order. On 5/8/2021 at 12:20 PM, in an interview with LPN #7, she stated that she has worked at the facility for two (2) months. LPN #7 revealed that back up pharmacy has not been used by the facility since March 2021. She further stated that Eliquis is not a cycle medication and must be reordered every time, causing a problem with getting that medication in a timely manner. On 5/8/2021 at 1:20 PM, in an interview with LPN #8, she revealed that she has worked at the facility for five (5) years. She stated during this time, there has not been any training on ordering or reordering medications. On 5/20/21 at 9:15 AM, in an interview with the (DON) she stated that she was aware that the nurses were unable to get medications. The DON said she had told the nurses to document everything in the resident charts, because she had told the Administrator that the medications were not coming in and she did not know what else to do. On 5/20/21 at 10:15 AM, in an interview with the Nurse Consultant, she stated she had spoken to	{M 700}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 118	{M 700}		

the DON and had recommended the DON to do in-services for the nurses on the appropriate way to obtain medications. She stated that the DON did not follow up with the in-services.

On 5/20/21 at 12:30 PM, in an interview with the Medical Doctor #2 (MD #2), she stated that she is aware that residents do not get their medications in a timely manner and there are times when residents have been without medications for days. She stated most of the time she is not notified for several days of residents not receiving their medications. The MD explained that when she has questioned the nurses regarding medications not being given, they would tell her the medications are on order. The MD said that she has met with the Administrator and DON regarding her concerns.

On 5/20/21 at 1:00 PM, in a telephone interview with the Medical Director, he revealed that he was aware of medications not being available, but he thought the problem had been corrected. The Medical Director stated that he should have known about the deficient issues within the Facility and followed up. He stated that the Quality Assurance and Performance Improvement (QAPI) Committee should have kept him informed.

On 5/20/21 at 2:00 PM, in an interview with the Administrator, he confirmed that he is aware that the Facility has a system failure with medication administration. He stated in April's QAPI meeting they discussed medications not being given. He further stated that the DON is supposed to call the pharmacy when a medication is not available.

On 5/20/21 at 2:30 PM, in a telephone interview with the Owner of the Facility, he stated that he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 119	{M 700}		

was aware of the medication issues within the Facility. He said, "but I did not know how severe it was." He stated that the QAPI program had failed.

Resident #4

Record review Resident #4's Admission Record revealed the resident was admitted to the Facility on 8/15/2017 and readmitted on 10/27/2020.

Record review of Resident #4's Diagnosis Information included COVID-19, Heart Failure, Type 2 Diabetes Mellitus, Recurrent Major Depressive Disorder, Acute Kidney Failure, Chronic Obstructive Pulmonary Disease, and Anxiety Disorder.

Record review of the Admission Minimum Data Set (MDS) dated 11/1/2020 revealed that Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicates that Resident #4 was cognitively intact.
On 11/17/2020, Resident #4 tested positive for COVID-19 and the Physician ordered the following medications:
1. Azithromycin Tablet 250 Give 500 milligrams (MG) by mouth one time a day for infection for one (1) day
2. Dexamethasone Tablet 6 MG Give 1 tablet by mouth one time a day for COVID-19 for 10 days
3. Zinc Sulfate Capsule 20 Mg Give 1 capsule by mouth two times a day for COVID-19
4. Famotidine Tablet 40 MG Give 2 tablets by mouth three times a day for COVID-19 for 30 days

Review of Resident #4's Medication Administration Record (MAR) revealed that the resident did not receive the following dose(s) of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 120	{M 700}		

medications because they were unavailable:
-Azithromycin 500 mg - 11/18/20 (1 of 1 dose missed)
-Dexamethasone - 11/18/2020, 11/20/2020 and 11/25/2020 (Three (3) missed doses) -Famotidine - 11/17/2020, 11/18/2020, 11/22/2020, 11/23/2020, 11/24/2020, 11/25/2020, and 11/27/2020 (Nine (9) missed doses)
-Zinc - 11/17/2020, 11/18/2020, 11/19/2020, 11/20/2020, 11/22/2020, 11/23/2020, 11/24/2020, 11/25/2020 (13 missed doses)

Resident #4 missed a total of 26 doses of significant medication ordered for COVID-19 from November 17 to November 27, 2020.

Resident #4 was transferred to the hospital Emergency Room for evaluation on 11/29/2020 and subsequently died.

On 05/04/2021 at 01:00 PM, in a telephone interview with Resident #4's mother, she revealed Resident #4 contracted COVID-19 at the facility and was transferred to the hospital. She stated she went to the hospital and her daughter's doctor told her there was nothing more that could be done for her daughter. She stated the doctor said that he did not know what had happened, but maybe she had missed medications. The resident's mother decided to take her daughter home rather than her being discharged back to the facility. She said her daughter expired on 12/22/2020.

Resident #12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 121	{M 700}		

Record review of Resident #12's Diagnosis Information included Unspecified Atrial Fibrillation, Peripheral Vascular Disease, Chronic Embolism and Thrombosis of Unspecified Deep Veins of Unspecified Lower Extremity, Chronic Kidney Disease, and Essential Hypertension.
Record review of the Quarterly Minimum Data Set (MDS) dated April 16, 2021, revealed that Resident #12 has a Brief Interview for Mental Status (BIMS) score of 14, which indicates that Resident #12 is cognitively intact.

Record review of Resident #12's Physician Orders revealed that the physician ordered the following medications:
1. Gabapentin Capsule 100 Grams (GM) Give 1 capsule by mouth three times a day for neuropathy (Ordered on 10/23/20)
2. Apixaban 5 mg by mouth two times a day for Deep Vein Thrombosis (Ordered 1/14/21)
Review of Resident #12's MAR reveals that the resident did not receive the following dose(s) of medications because they were unavailable:
-Gabapentin on 4/5/21, 4/6/21, 4/7/21, 4/8/21, 4/9/21, 4/10/21, 4/11/21, 4/12/21, 5/2/21, 5/3/21, and 5/7/21 (24 missed doses)
-Apixaban on 4/13/21, 4/14/21, 4/15/21, 4/16/21, 4/17/21, 4/18/21, 4/19/21, 4/25/21, 4/26/21, 4/27/21, 5/9/21 and 5/13/21 (13 missed doses)

The total number of doses of significant medications that Resident #12 missed from April 1 to May 16, 2021, totaled 37.

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

Resident #17

Record review the Admission Record revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 122 Resident #17 was originally admitted to the facility on 3/4/2021 and readmitted on 3/10/2021. Record review of Resident #17's Diagnosis Information revealed, Osteomyelitis of Vertebra, Sacral and Sacrococcygeal Region, Unstageable Pressure Ulcer of Sacral Region, Gram Negative Sepsis, Congestive Heart Failure, Atherosclerotic Heart Disease, Diabetes Mellitus due to Underlying Condition with Foot Ulcer, Chronic Obstructive Pulmonary Disease, Chronic Peripheral Venous Insufficiency and Essential Hypertension. Record review of the 5-Day Minimum Data Set (MDS) dated March 12, 2021, revealed that the resident has a Brief Interview for Mental Status (BIMS) score of 15, which indicates that Resident #17 is cognitively intact. Record Review of Resident #17's Physician Orders revealed the following Physician Orders: 1. Insulin Glargine Solution Inject 60 units subcutaneously at bedtime related to Diabetes Mellitus due to underlying condition with foot ulcer (Ordered 3/4/21) 2. Insulin Aspart Solution Inject 5 units subcutaneously three times a day related to Diabetes Mellitus due to underlying condition with foot ulcer (Ordered 3/4/21) 3. Metoprolol Tartrate Tablet 25 MG Give 1 tablet by mouth two times a day related to Essential Hypertension (3/4/21) 4. Furosemide Tablet 40 MG Give 1 tablet by mouth one time a day related to Congestive Heart Failure (Ordered 3/5/21) 5. Isosorbide Mononitrate ER Tablet 60 MG Give 1 tablet by mouth one time a day related to Atherosclerotic Heart Disease (Ordered 3/4/21) 6. Insulin Glargine Solution Inject 60 units	{M 700}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 123	{M 700}		

subcutaneously in the evening related to Diabetes Mellitus due to underlying condition with foot ulcer (Ordered 3/10/21)
7. Insulin Glargine Solution 100 Init/ML Inject 15 units subcutaneously in the morning for Diabetes Mellitus due to underlying condition with foot ulcer (Ordered 3/4/21)
8. Insulin Aspart Solution Inject 5 units subcutaneously three times a day related to Diabetes Mellitus due to underlying condition with foot ulcer (Ordered 3/10/21)
9. Furosemide Tablet 20 MG Give 1 tablet by mouth one time a day related to Congestive Heart Failure (Ordered 3/10/21)
10. Clindamycin HCL Capsule 300 MG Give 1 capsule by mouth every dayshift for infection related -Gram-Negative Sepsis (Ordered 3/10/21)
11. Levofloxacin Tablet 750 MG Give 1 tablet by mouth one time a day related to Gram Negative Sepsis for 14 days (Ordered 3/10/21)
12. Cipro Tablet 500 MG Give 1 tablet by mouth every 24 hours for Osteomyelitis for 56 days (Ordered on 3/24/21)
13. Levofloxacin in D5W Solution 750 MG/150 ML Use 750 MG intravenously every 24 hours for osteomyelitis for 42 days infuse @100 ML/HR to PICC (Ordered 4/12/21)
14. Ceftriaxone Sodium Solution Reconstituted 1 GM intravenously one time a day for sacral wound infection for 14 days (Ordered 5/1/21)

Review of Resident #17's MAR reveals that the resident did not receive the following dose(s) of ordered medications because they were unavailable:
-Insulin Glargine Solution 60 units on 3/4/21 (One (1) missed dose)
-Insulin Aspart Solution 5 units on 3/4/21 and 3/5/21 (Three (3) missed doses)
-Metoprolol Tartrate 25 MG on 3/4/21 and 3/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 124 (Two (2) missed doses) -Furosemide Tablet 40 MG on 3/5/21, 3/22/21, 3/23/21, 3/29/21, 4/5/21 and 4/12/21 (Five (5) missed doses) -Isosorbide Mononitrate ER Tablet 60 MG on 3/11/21 (One (1) missed dose) -Insulin Glargine Solution Inject 60 units on 4/15/21 (One (1) missed dose) -Insulin Glargine Solution 15 units on 3/5/21 (One (1) missed dose) -Insulin Aspart Solution 5 units on 3/12/21 (One (1) missed dose) -Furosemide Tablet 20 MG on 3/23/21, 3/29/21 and 4/5/21 (Three (3) missed doses) -Clindamycin HCL Capsule 300 MG on 3/11/21 and 3/12/21 (Two (2) missed doses) -Levofloxacin Tablet 750 MG on 3/11/21 and 3/12/21 (Two (2) missed doses) -Levofloxacin in D5W 750 MG/ML on 4/12/21 (One (1) missed dose) -Cipro Tablet 500 MG on 4/8/21, 4/9/21 and 4/10/21 (Three (3) missed doses) -Ceftriaxone Sodium Solution 1 GM on 5/1/21 (One (1) missed dose) The total number of doses of significant medications that Resident #17 missed from March 1, 2021, to May 1, 2021, totaled 27. Record review revealed that Resident #17 did not receive his insulin and antibiotic therapy as ordered and likely contributed to worsening of the resident's wounds. Resident #7 Record review of the Admission Record revealed Resident #7 was initially admitted on 9/4/2018 and readmitted on 4/13/2021.	{M 700}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 125	{M 700}		

Record review of Resident #7's Diagnosis Information included Type 2 Diabetes Mellitus, Heart Failure, Cardiomegaly, Cerebral Infarction, and Essential Hypertension.

Record review of the Discharge Minimum Data Set (MDS) dated April 18, 2021, revealed that the Resident #7 has a Brief Interview for Mental Status (BIMS) score of 05, which indicates that Resident #7 is severely cognitively impaired.

Record Review of Resident #7's Physician Orders revealed the following Physician Orders:
1. Xarelto Tablet 20 MG Give 1 tablet by mouth one time a day for Atrial Fibrillation with supper (Ordered 8/24/20)
2. Augmentin Tablet 875-125 MG Give 1 tablet by mouth two times a day for infection for 7 days. (Ordered 4/13/21)

Review of Resident #7's MAR reveals that the resident did not receive the following dose(s) of ordered medication because it was unavailable:
-Xarelto on 3/9/21, 3/30/21, 3/31/21, 4/1/21, 4/13/21, 4/14/21, 4/15/21, and 4/17/21 (Eight (8) missed doses)
-Augmentin on 4/13/21 (One (1) missed dose)
The total number of doses of significant medications that Resident #7 missed from March 1 to April 30, 2021, totaled 9.
Review of Resident #7's Admission Record revealed that the resident has Atrial Fibrillation (a heart condition that can cause stroke or death).
Resident #10
Record review of the Admission Record revealed Resident #10 was admitted to the facility on 3/15/2021.
Record review of Resident #10's Diagnosis Information included Alcohol Dependence, Seizures, Stroke, Alcohol Abuse with Withdrawal,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 126 and Dementia. Record review of the Admission Minimum Data Set (MDS) dated March 22, 2021, reveals Resident #10 has a Brief Interview for Mental Status (BIMS) score of 03, which indicates that Resident #10 is severely cognitively impaired. Review of Resident #10's Physician orders revealed the following Physician orders: 1. Clopidogrel Bisulfate 75 mg by mouth one time a day related to stroke (Ordered 3/16/21) 2. Levetiracetam Solution 100 mg/milliliter (ML) by mouth two times a day related to seizures (Ordered 3/15/21) 3. Cyanocobalamin Tablet 1000 MCG give 1 tablet by mouth one time a day related to Alcohol Dependence (Ordered 3/16/21) 4. Folic Acid Tablet 1 MG Give 1 Tablet by mouth one time a day related to Alcohol Dependence (Ordered 3/16/21) 5. Gabapentin Capsule 100 MG Give 1 capsule by mouth three times a day for Neuropathy (Ordered 3/15/21) 6. Thiamine HCL Tablet 100 MG Give 1 tablet by mouth one time a day related to Alcohol Dependence (Ordered 3/16/21) Review of Resident #10's MAR reveals that the resident did not receive the following dose (s) of medications because they were unavailable: -Clopidogrel Bisulfate on 3/16/21, 3/17/21, 3/31/21, 4/3/21, 4/4/21, 4/5/21, 4/6/21, 4/8/21, 4/9/21, 4/12/21, 4/13/21, 4/14/21, and 4/15/21 (13 missed doses) -Levetiracetam Solution one dose of the ordered medication on 3/16/21, 3/17/21, 4/2/21 and 4/19/21 (Four (4) missed doses) -Cyanocobalamin on 3/16/21, 3/17/21, 3/18/21, 3/22/21, 3/23/21, and 3/24/21 (Nine (9) missed doses)	{M 700}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 127 -Folic Acid on 3/16/17, 3/18/21, 4/3/21, 4/4/21, 4/5/21, 4/6/21, 4/8/21, 4/9/21, 4/12/21, 4/13/21, 4/14/21, and 4/15/21 (Ten (10) missed doses) -Gabapentin on 3/16/21, 3/17/21, 3/23/21, 4/1/21, 4/2/21, 4/3/21, 4/4/21, 4/5/21, 4/6/21, 4/7/21, 4/8/21, 4/8/21, 4/10/21, 4/11/21, 4/12/21, 4/13/21, 4/14/21 and 4/15/21 (41 missed doses) -Thiamine on 3/16/21, 3/17/21 and 4/2/21 (2 missed doses) The total number of doses of significant medications that Resident #10 missed from March 1 to April 30, 2021, totaled 79. Resident #11 Record review of the Admission Record revealed Resident #11 was admitted to the facility on 12/15/2018. Record review of Resident #11's Diagnosis Information included Type 2 Diabetes Mellitus, Seizures, Chronic Pancreatitis, Essential Hypertension, Vitamin B12 Deficiency Anemia, Recurrent Depressive Disorders, Bipolar Type Schizoaffective Disorder, and Chronic Obstructive Pulmonary Disorder. Record review of the Quarterly Minimum Data Set (MDS) dated May 5, 2021, reveals that the Resident #11 has a Brief Interview for Mental Status (BIMS) score of 15, which indicates that Resident #11 is cognitively intact. Record Review of the Physician orders revealed that Resident #11 had the following Physician Orders: 1. Amantadine HCL 100 mg by mouth two (2) times a day for Extrapyramidal Side Effects (Ordered 12/15/18)	{M 700}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 128 2. Creon Delayed Release two (2) capsules by mouth before meals for Chronic Pancreatitis (Ordered 9/15/20) 3. Divalproex Sodium Delayed Release 500 mg by mouth two (2) times a day for convulsive disorder (Ordered 12/15/18) 4. Escitalopram Oxalate 20 mg by mouth a day for Depression (8/17/19) 5. Losartan Potassium 25 mg by mouth in the morning related to Essential (Primary) Hypertension (Ordered 7/6/20) 6. Metformin HCL 1000 mg by mouth two (2) days a day for Diabetes (Ordered 12/17/18) 7. Risperdal 2 mg by mouth two (2) times a day related to Bipolar Disorder (8/8/19) Review of Resident #11's MAR reveals that the resident did not receive the ordered medications on the following dates, as medication was unavailable: -Amantadine HCL on 3/1/2021, 3/2/2021, 3/4/2021, 3/8/2021, 3/9/2021, 3/10/2021, and 3/11/2021 (Seven (7) doses) -Creon on 3/29/2021 and 3/30/31 (Five (5) doses) -Divalproex Sodium on 3/1/2021, 3/2/21021, 3/4/2021, 3/8/2021, 3/9/2021, 3/10/2021, 3/11/2021 4/14/2021 (Nine (9) doses) -Escitalopram Oxalate on 3/1/2021, 3/2/2021, 3/4/2021, 3/8/2021, 3/9/2021, 3/10/2021, and 3/11/2021 (Seven (7) doses) -Losartan Potassium on 3/1/2021, 3/2/2021, 3/4/2021, 3/8/2021, 3/9/2021, 3/10/2021, and 3/11/2021 (Seven (7) doses) -Metformin on 3/1/2021, 3/2/2021, 3/3/2021, 3/4/2021, 3/8/2021, 3/9/2021, 3/10/2021 and 3/11/2021 (Nine (9) doses) -Risperdal on 3/1/2021, 3/2/2021, 3/3/2021, 3/5/2021, 3/8/2021, 3/9/2021, 3/10/2021 and 3/11/2021 (13 doses)	{M 700}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 129	{M 700}		

The total number of missed doses of significant medications that Resident #11 missed from March 1 to April 30, 2021, totaled 57.

On 5/6/2021 at 9:40 AM, in an interview with Resident #11, she revealed the resident that her medications are not always available. She was able to recall not getting Metformin for three (3) consecutive days. She said that if there was a time that she did not take her medications, she did not refuse them, it was because the Facility ran out of her medications. She further stated that this happens almost monthly.

Resident #8

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

Record review of the Quarterly Minimum Data Set (MDS) dated April 13, 2021, revealed that Resident #8 has a Brief Interview for Mental Status (BIMS) score of 13, which indicates that Resident #8 is cognitively intact.

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

Physician orders reveals that Resident #8 had the following Physician Orders:
1. Chewable Aspirin Tablet 81 mg by mouth one time a day related to Congestive Heart Failure (Ordered 8/7/19)
2. Carvedilol Tablet 6.25 mg by mouth two (2) times a day related to Essential Hypertension

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 130 (Ordered 8/7/19) 3. Clopidogrel Bisulfate 75 mg by mouth one (1) time a day for blood clot prevention (Ordered 8/7/19) 4. Escitalopram Oxalate 20 mg by mouth one time a day for Depression (Ordered 8/7/19) 5. Jardiance 25 mg by mouth one (1) time a day related to Type 2 Diabetes Mellitus (Ordered 4/7/20) 6. Lantus Solution 100 unit/mL 30 units subcutaneously one (1) time a day related to Type 2 Diabetes Mellitus (Ordered 8/20/20) 7. Losartan Potassium Tablet 25 MG Give 1 tablet by mouth one time day related to Essential Hypertension (Ordered 1/27/20) 8. Metformin HCL Extended Release give 500 mg by mouth one (1) time a day related to Type 2 Diabetes Mellitus (Ordered 4/7/20) 9. Bactrim DS 800-180 mg by mouth two times a day for infection to left great toe for ten (10) days (Ordered 2/23/21) Review of Resident #8's MAR reveals that the resident did not receive the ordered medications on the following dates, as the medication was unavailable: -Aspirin on 3/1/2021, 3/2/2021, 3/4/2021, 3/5/2021, 3/10/2021, and 3/11/2021 (Six (6) missed doses) -Carvedilol on 3/1/2021, 3/4/2021, 3/5/2021, and 3/10/2021 (Four (4) missed doses) -Clopidogrel Sulfate on 3/1/2021, 3/2/2021, 3/4/2021, 3/5/2021, 3/5/2021, 3/9/2021, and 3/10/2021 (Seven (7) missed doses) -Escitalopram Oxalate on 3/1/2021, 3/2/2021, 3/4/2021, 3/5/2021, 3/10/2021, and 3/11/2021 (Six (6) missed doses) -Jardiance on 3/1/2021, 3/2/2021, 3/4/2021, 3/5/2021, 3/10/2021, and 3/11/2021 (Six (6) missed doses)	{M 700}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 131 -Lantus on 3/1/2021, 3/2/2021, 3/4/2021, 3/5/2021, 3/10/2021, and 3/11/2021 (Six (6) missed doses) -Losartan Potassium on 3/1/2021, 3/2/2021, 3/4/2021, 3/5/2021, 3/7/2021, 3/10/2021, and 3/11/2021 (Seven (7) missed doses) -Metformin on 3/1/2021, 3/4/2021, 3/5/2021, and 3/9/2021 (Four (4) missed doses) -Bactrim DS on 3/1/21, 3/4/21 and 3/5/21 (Three (3) missed doses) The total number of doses of significant medications that Resident #8 missed from March 1 to April 30, 2021, totaled 49. Resident #16 Record review the Admission Record reveals Resident #16 was admitted to the facility on 2/26/21 and readmitted to the facility on 4/16/21. Record review of Resident #16's Diagnosis Information include Schizophrenia, Seizures, Essential Hypertension, and Cellulitis of Left Lower Limb. Record review of the admission Minimum Data Set with an assessment reference date of 4/21/21 revealed Resident #16 had a Brief Interview of Mental Status score of 14 indicating that the resident was cognitively intact. Record Review of the Physician orders reveals that Resident #16 had the following Physician Orders: 1. Amlodipine Besylate 10 MG give 1 tablet by mouth one time a day related to Essential Hypertension (Ordered 2/26/21) 2. Furosemide 20 MG give 1 tablet by mouth one time a day related to Edema (Ordered	{M 700}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 132 2/26/21) 3. Lisinopril 10 MG give 1 tablet by mouth one time day related to Essential Hypertension (Ordered 2/26/21) 4. Levetiracetam 250 MG give 1 tablet by mouth one time a day related Seizures (Ordered 2/26/21) 5. Metoprolol Tartrate 50 MG give 1 tablet by mouth two times a day related to Essential Hypertension (Ordered 2/26/21) 6. Haldol Solution 5 MG/ML Inject 5 m intramuscularly every 6 hours related to Restlessness and agitation (Ordered 2/26/21) 7. Quetiapine Fumarate 100 MG give 2 tablets by mouth two times a day related to Schizophrenia (Ordered 4/16/21) 8. Fluoxetine HCL 10 MG give 1 tablet by mouth one time a day related to Schizophrenia (Ordered 4/16/21) 9. Divalproex Sodium Tablet Delayed Release 500 MG Give 1 tablet by mouth one time a day related to Seizures (Ordered 4/17/21) 10. Bactrim DS 800-160 MG give 1 tablet by mouth two times a day for cellulitis (Ordered 4/27/21) 11. Haldol Tablet 10 MG Give 1 tablet by mouth two times a day for Agitation Review of Resident #16's MAR reveals that the resident did not receive the ordered medications on the following dates, as the medication was unavailable: -Amlodipine Besylate on 3/1/21 and 4/16/21 (Two (2) missed doses) -Furosemide on 3/1/21, 3/2/21 and 4/16/21 (three (3) missed doses) -Lisinopril on 3/1/21, 3/2/21, and 4/16/21 (Three (3) missed doses) -Levetiracetam on 3/2/21, 4/16/21, 4/26/21 and 4/27/21 (Four (4) missed doses)	{M 700}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 133 -Metoprolol on 3/1/21, 3/2/21, 4/16/21, 4/26/21 and 4/27/21 (Seven (7) missed doses) -Quetiapine Fumarate on 3/1/21, 3/2/21, 4/16/21, 4/17/21 and 4/18/21 (Four (4) missed doses) -Fluoxetine on 4/17/21 (One (1) missed dose) -Divalproex Sodium on 4/17/21 and 4/19/21 (Two (2) missed doses) -Bactrim DS on 4/27/21, 4/28/2/1 and 4/30/21 (Three (3) missed doses) -Haldol Solution on 5/2/21, 5/3/21, 5/4/21, 5/5/21 and 5/6/21 (15 missed doses) -Haldol Tablet on 5/6/21 (One (1) missed dose) The total number of doses of significant medications that Resident #16 missed from March 1 to May 9, 2021, totaled 45. Resident # 1 Record review of Resident #1's Admission Record revealed Resident #1 was admitted to the facility on 3/17/2021. Record review of Resident #1 Diagnosis Information included Unspecified Dementia with Behavioral Disturbance, Epilepsy, Cognitive Communication Deficit, Generalized Anxiety Disorder, Mood Disorder with Known Physiological Condition with Manic Features, Hypothyroidism, and Angina Pectoris. Record review of the Admission Minimum Data Set (MDS) dated 3/23/2021, revealed a Brief Interview of Mental Status (BIMS) score of 00, indicating that Resident #1 has severe impairment in cognition. Record Review revealed that Resident #1 had the following Physician Orders: 1. Quetiapine Fumarate Tablet 25 MG Give 1	{M 700}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 134	{M 700}		

tablet by mouth at bedtime for Dementia (Ordered 3/25/21)
2. Aricept Tablet 10 MG Give 1 tablet by mouth at bedtime for Dementia (Ordered 4/30/21)
3. Seroquel Tablet 300 MG Give 300 mg by mouth at bedtime for Dementia with Behavioral problems related to Mood Disorder due to known physiological condition with manic features. (Ordered 4/30/21)
4. Alprazolam Tablet 1 MG Give 1 tablet by mouth two times a day for Agitation and Anxiety (Ordered 4/5/21)
5. Divalproex Solution Tablet Delayed Release 250 MG Give 1 tablet by mouth two times a day related to Epilepsy (Ordered 4/30/21)
6. Namenda Tablet 5 MG Give 1 tablet by mouth two times a day related to unspecified Dementia with Behavioral Disturbance (Ordered 4/30/21)
8. Olanzapine Tablet 10 MG Give 1 tablet by mouth three times a day related to Mood Disorder due to known physiological condition with Manic Features (Ordered 4/30/21)
9. Alprazolam Tablet 0.5 MG Give 1 tablet by mouth one time a day related to Generalized Anxiety Disorder (Ordered 5/1/21)
10. Prednisone Tablet 10 MG Give 1 tablet by mouth one time a day for right foot pain for 5 days (Ordered 5/2/2021)

Review of Resident #1's MAR reveals that the resident did not receive the ordered medications on the following dates, as the medication was unavailable:
-Quetiapine Fumarate on 3/27/21 and 4/30/21 (Two (2) doses missed)
-Aricept on 4/30/221 ((One (1) dosed missed)
-Seroquel on 4/30/21 (One (1) dose missed)
-Alprazolam on 5/5/21 and 5/6/21 (Two (2) missed doses)
-Divalproex on 4/30/21, 5/5/21 and 5/6/21 (Three

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 135 (3) missed doses) -Namenda on 4/30/21 (One (1) dose missed) -Olanzapine on 5/5/21 and 5/6/21 (Four (4) doses missed) -Alprazolam on 5/5/21 and 5/6/21 (Two (2) doses missed) -Prednisone on 5/2/21, 5/5/21 and 5/6/21 (Three (3) doses missed) The total number of doses of significant medications that Resident #1 missed from March 17 to May 7, 2021, totaled 19. Resident #2 Record review of the Admission Record revealed Resident #2 was admitted to the facility on 6/19/2020. Record review of Resident #2's Diagnosis Information included Type 2 Diabetes Mellitus, Chronic Embolism with Thrombosis, Unspecified Fracture of Shaft of Left Fibula, Atherosclerotic Heart Disease, Pressure Ulcer of Sacral Region, and Chronic Kidney Disease. Record review of Resident #2's Quarterly Minimum Data Set (MDS) dated 3/9/2021, reveals a Brief Interview for Mental Status (BIMS) score of 07. A BIMS score of 07 indicates Resident #2 is severely cognitively impaired. Record Review of the Physician orders reveals that Resident #2 had the following Physician Orders: 1. Eliquis 5 MG Give 5 mg by mouth two (2) times a day for anticoagulant (Ordered 6/18/20) Review of Resident #2's MAR reveals that the resident did not receive the ordered dose (s) of Eliquis 3/1/21 (One (1) dose missed), 3/2/21	{M 700}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 136	{M 700}		

(One (1) dose missed), 3/4/21 (One (1) missed dose), 3/5/21 (One (1) missed dose), 3/8/21 (Two (2) missed doses), 3/9/21 Two (2) missed doses), 3/10/21 (One (1) missed dose), 3/18/21 (One (1) missed dose), 3/19/21 (One (1) missed dose) , 3/22/21 (One (1) missed dose), 3/23/21 (One (1) missed dose), 4/8/21 (Two (2) missed doses), 4/9/21 (Two (2) missed doses), 4/10/21 (One (1) missed dose), 4/12/21 (Two (2) missed doses) and 4/13/21 (Two (2) missed doses), as the medication was unavailable.

The total number of doses of significant medications that Resident #2 missed from March 1 to April 30, 2021, totaled 22.

Resident #9

Record review of the Admission Record revealed Resident #9 was originally admitted on 10/16/2020 and re-admitted on 2/11/2021.

Record review of Resident #9's Diagnosis Information included Type 2 Diabetes Mellitus, Essential Hypertension, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Peripheral Vascular Disease, and Cerebral Infarction.

Record review of the Quarterly Minimum Data Set (MDS) dated April 8, 2021, revealed that the resident has a Brief Interview for Mental Status (BIMS) score of 15, which indicates that the resident is cognitively intact.

Review of Resident #9's Physician Orders reveal orders for:
1. Aspirin EC Tablet Delayed Release 81 MG Give 1 tablet by mouth one time a day for Cerebrovascular Accident (CVA) (Ordered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 700}	Continued From page 137 10/20/20) 2. Amlodipine Besylate Tablet to MG Give 1 tablet by mouth one time a day for Essential Hypertension (Ordered 11/3/20) 3. Potassium Chloride ER Tablet Extended Release 20 MEQ Give on tablet by mouth one time a day for diuretic use (Ordered 1/12/21) 4. Losartan Potassium Tablet 50 MG Give 50 mg by mouth in the morning for Hypertension (Ordered 1/15/21) 5. Furosemide Tablet 40 MG Give 1 tablet by mouth in the morning for Hypertension/Edema related to Essential Hypertension (Ordered 1/26/21) 6. Humulin 70/30 Suspension 100Unit/ML Inject 50 units subcutaneously two times a day related to Type 2 Diabetes Mellitus (Ordered 2/11/21) Review of Resident #9's's MAR reveals that the resident did not receive the ordered medications on the following dates, as the medication was unavailable: -Aspirin EC Tablet on 3/1/21 and 3/9/21 (Two (2) doses missed) -Amlodipine Besylate on 3/1/21 and 3/9/21 (Two (2) doses missed) -Potassium Chloride ER on 3/4/21, 3/8/21 and 3/9/21 (Three (3) doses missed) -Losartan Potassium on 3/1/21 and 3/8/21 (Two (2) doses missed) -Furosemide on 3/1/21, 3/4/21, 3/8/21 and 3/10/21 (Four (4) doses missed) -Humulin 70/20 on 3/1/21, 3/8/21 and 3/10/21 (Three (3) doses missed) The total number of doses significant medications that Resident #9 missed from March 1 to April 30, 2021, totaled 16. Resident #15	{M 700}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 700}	Continued From page 138 Record review of the Admission Record revealed Resident #15 was admitted to the facility on 11/25/2020. Record review of Resident #15's Diagnosis Information included Chronic Pain Syndrome, Type 2 Diabetes Mellitus, Essential Hypertension, and Hypertensive Heart Disease. Record review of Resident #15's Quarterly Minimum Data Set (MDS) dated 2/25/2021, revealed a Brief Interview for Mental Status (BIMS) score of 12 indicating Resident #15 is moderately cognitively impaired. Review of Resident #15's Physician Orders revealed that the Physician Orders include orders for Lyrica 100 mg by mouth three (3) times a day related to Muscle Spasm of Back. Review of the Resident #15's MAR reveals that the resident did not receive the ordered medicine on 3/9/19 (Two (2) doses missed), 3/18/21 (Two (2) doses missed) and 4/6/21 (Three (3) doses missed) because it was unavailable. The total number of doses of significant medications that Resident #10 missed from March 1 to April 30, 2021, totaled 7. On 5/13/21 at 11:55 AM in an interview with Resident #15, he revealed that he needs his Lyrica and pain medications and would never refuse them. He stated that the only time he does not take his medications is when the facility has run out of them. Removal Plan: The ADON/ICC was in-serviced regarding the process for obtaining medications from the	{M 700}		

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	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 700}	Continued From page 139	{M 700}		

pharmacy, including the back-up pharmacy process, on 5/22/2021 by the Regional Nurse Consultant. The ADON initiated education regarding obtaining medications from the pharmacy, the back-up pharmacy process, and completing match backs daily for all nurses on 5/22/2021.
The attending physician was notified of the missed medications on 5/25/2021 by Medical Records with no new orders at that time.
On 6/01/21, the Owner sent a letter of termination of services for the current Pharmacy Service and a new company will take over in 30 days. There will be no lapse in pharmacy services for the residents.
Validation:
The State Survey Agency (SSA) validated through interview with the Assistant Director of Nursing/Infection Control Coordinator (ADON/ICC) that she had been in-serviced by the Regional Nurse Consultant on obtaining medications from the pharmacy that included information about the back-up pharmacy process.
The SSA validated through review of sign-in sheets and interviews with licensed nurses the ADON/ICC conducted in-services for all licensed nurses regarding obtaining medications from the pharmacy, the back-up pharmacy process, and completing match backs daily.
The SAA validated through interview with the attending physician that he had been notified of missed medications.
The SSA validated through interviews with licensed nurses from all shifts that in-services conducted on obtaining medications were mandatory and attendance was required before being permitted to work.
The SSA validated through interviews that the facility is now using Liberty Pharmacy, with Walgreens as their back-up. All nurses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 700}	Continued From page 140 interviewed, including the ADON verified that they were receiving the medications as ordered and if they ran out, they called Liberty Drugs and the medications would be delivered the same day. The nurses stated that they were no longer having a problem with having the medications that were ordered for their residents.	{M 700}		
{M 735}	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis.	{M 735}		7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 735}	Continued From page 141 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute is not met as evidenced by: Level IV Based on observations, resident interviews, staff interviews, and record review the facility failed to completely and accurately document in the clinical records for eight (8) of nine (9) residents reviewed for wounds. Residents #3, #5, #6, #7, #12, #13, #14, and #17. The Facility's failure to accurately document in the clinical records puts 8 of 9 residents at risk for the likelihood of serious harm, serious injury, serious impairment or death.	{M 735}	1. On 5/23/2021, the Director of Nursing was educated by the wound care-certified Regional Nurse Consultant (RNC) regarding the skin and wound care process, including documentation of wounds. On 5/24/21, Corporate Management approved Wound Care Specialists from other facilities to work in the Facility to assist with Medical Record documentation. On 5/28/2021, the Certified Wound Care Nurse and Minimal Data Set Coordinator assessed wounds for staging and treatment for Residents #3, #6, #7, #13, #14, and #17 to ensure	

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	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 735}	Continued From page 142 This situation was determined to be an Immediate Jeopardy (IJ) on 05/21/2021 and was determined to exist on 04/06/2021 when the facility failed to assess wounds accurately and document findings in medical records. The IJ was not removed prior to exit on 05/26/2021 and is considered ongoing. The IJ and Substandard Quality of Care (SQC) existed at M735- Medical Record Management. The IJ was not removed prior to the State Agency (SA) exit on 5/26/2021 and was considered ongoing. The facility provided a Credible Removal Plan of IJ, which was accepted by the Centers for Medicare and Medicaid Services (CMS) on 6/15/21. CMS authorized the State Agency to conduct a revisit in order to determine if corrective actions implemented by the facility were able to demonstrate removal of the immediate jeopardy. The validation of the Credible Removal Plan of IJ from 6/16/21 through 6/17/21 was accomplished through staff interview, resident interview, family interview, record review, in-service review, and observation. The facility provided evidence the facility had implemented corrective actions listed in the Credible Allegation of Removal Plan of IJ. The IJ was determined to be removed on 6/12/21. Upon validation, the IJ for M735 has been lowered from the severity of a Level IV to the severity of Level II. The facility will remain out of compliance at the Severity of Level II that is not an Immediate Jeopardy. The facility will remain out of compliance while the facility develops and implements the Plan of Correction (PoC); and	{M 735}	correct treatments were implemented and that interventions were appropriate for the wounds identified. Any necessary changes identified in treatment and medications were reported to the Nurse Practitioner. Any new physician orders were entered, care plans were reviewed for needed revisions and revised according as orders were approved. Resident #5 discharged on 01/21/21. Resident #12 discharged on 5/17/21. Beginning 5/28/21, the Assistant Director of Nursing/Infection Control Coordinator or Minimum Data Set Coordinator daily check nursing documentation entered into the Medical Record to ensure that no care is missed, and all care is documented. 2. All residents with skin integrity concerns have the potential to be affected by the deficit practice cited. 3. Beginning 5/28/21 and continuing, the ADON/ICC, Certified Wound Care Nurse and RNC educated all nursing staff (Registered Nurses, Licensed Practical Nurses, Certified Nurse Aides) on the requirements of documentation of the following: wound measurements, Braden scale, notification of families about wounds and/or status of wounds, treatments provided, and written physician orders. The in-services were either in-person, in a classroom setting, or 1:1, either in person or by telephone. Any staff member not attending the initial in-service will be educated upon return and will not be permitted to work unless education is completed. Any staff member who fails to comply with the direction included in the in-services will be further educated and/or progressively disciplined. On 6/1/21 and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 735}	Continued From page 143 while the facility's Quality Assessment and Assurance Committee monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Resident #3 Record review for Resident #3's Admission Record revealed the facility initially admitted Resident #3 on 02/24/2019 with the diagnoses of Atrial Fibrillation, Type 2 Diabetes Mellitus, Pressure Ulcer Sacral Region Stage 3, Hemiplegia and Hemiparesis, Peripheral Vascular Disease, Cardiomegaly, and High Blood Pressure. Record review Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) dated for 2/15/21, Section M revealed Resident #3 had a Stage 3 pressure ulcer. Record review of Resident #3's Treatment Administration Record (TAR) for January 2021 revealed omitted documentation for the treatment of Stage 3 ulceration to sacrum on 1/1/21, 1/2/21, 1/8/21, 1/9/21, 1/10/21, 1/15/21, and 1/16/21 for a total of seven (7) entries omitted in January. Record review of the TAR for March 2021 revealed omitted documentation for the treatment of sacral wound on 3/9/21, 3/11/21, 3/15/21, 3/22/21, 3/27/21, and 3/28/21 for a total of six (6) entries omitted in March. Review of April 2021 TAR revealed omitted documentation for the treatment of sacral wound on 4/2/21, 4/3/21, and 4/7/21 for a total of three (3) entries omitted in April. Record review of the Weekly Pressure Injury	{M 735}	6/2/21, the Certified Wound Care Nurse, MDS Coordinator, and ADON/ICC conducted an audit of all other resident□s charts for missed documentation, such as any skin assessments or any treatments not documented. All residents□ comprehensive care plans were also checked for potential skin issues and were updated based on findings from the assessments. Beginning 6/03/21, an additional Certified Wound Care Nurse began auditing all residents for a new complete skin assessment. Any additional areas noted were communicated to the provider for new or revised orders. 4. The Director of Nursing or Assistant Director of Nursing will review the wound care log weekly times four weeks beginning the week of 7/1/21 and then monthly times three months beginning 8/1/21. Residents identified with wounds will be discussed during the weekly Persons At Risk meeting beginning the week of 7/1/21. Findings will be brought to Quality Assurance Performance Improvement monthly beginning 7/2/21 for review, revision, or resolution of the plan. Independent monitoring began 6/7/21 by an outside consulting firm is being performed for compliance assistance. The Administrator will report to the Governing Body and Management Company the monitoring outcomes monthly beginning 7/1/21 for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 735}	Continued From page 144 Record for Resident #3 revealed one record dated 1/11/2021 which was incomplete. There are no other records indicating evaluation or assessment of wounds for January 1, 2021 through May 8, 2021. Resident #5 Record review of Resident #5's Admission Record revealed the facility admitted Resident #5 on 05/19/2020 with the diagnoses including but not limited to Pressure Ulcer of right buttock Stage 2, and Pressure ulcer of left heel, unstageable, which indicated the pressure ulcers to right buttock and left heel were present on admission. Resident #5 was discharged to another facility on 1/21/2021. Record review of Resident #5's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of November 16, 2020, Section M of the MDS revealed Resident #5 had one (1) Stage 2 and one (1) unstageable wound. The latest Discharge MDS with ARD of 1/21/2021 revealed the same findings as the quarterly MDS. Record review of Resident #5's Initial Weekly Wound Pressure report dated 05/20/2020, revealed Resident #5 was admitted with a wound on the left heel, inner aspect, unstageable, with measurements of 2 cm x 1.4 cm x 0.2 cm and wound to right buttock Stage two with measurements 1 cm x 1 cm x 0.2 cm. Review of Resident #5's Nurse Progress Notes dated 05/25/2020 revealed a new area to left gluteal fold with partial thickness measurements of 1.5 cm x 0.5 cm x0.1 cm with cleansed area with wound cleanser pat dry, zinc oxide applied to area. There was no weekly body audit with the	{M 735}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 735}	Continued From page 145 new wound to left gluteal fold with measurements. Review of Resident #5's weekly body audit dated 06/17/2020 revealed no measurements and continue treatment to coccyx and right foot. Further record review of Resident #5's weekly body audits dated 09/02/20, 09/28/20, 10/14/20 revealed body audits with wounds right and left buttock with no measurements recorded. A record review of Resident #5's TAR revealed an order for Santyl Ointment 250 unit/ gram (GM) TAR had missing documentation for 5/21/20 thru 5/23/20 ,5/27/20 thru 5/29/20. A record review of the TAR for Stage 2 Right Buttock wound care on 5/21/20 , 5/22/20, 5/27/20, 5/28/20 and 5/29/20 revealed no nurse initials for those dates. The unstageable ulceration to left heel inner aspect wound care for Hydrogel had missing documentation for 5/28/20 thru 5/29/20. Resident #6 Record review of Resident #6's Physician Order dated 1/21/21 revealed an order to changed Duoderm dressings to bilateral ankles every three (3) days. Record review reveals that there are no records indicating consistent assessment or measurement of ankle wounds from January 28 through May 8, 2021. A Pressure Report dated 05/08/2021 revealed Resident # 6 with pressure wounds to bilateral ankles with measurements left ankle 1.5 cm x 1.2 cm and right ankle 1.5 cm x 1.5 cm with Stage 2 noted with eschar tissue per DON skin assessment.	{M 735}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 735}	Continued From page 146 Record review of Resident #6's weekly body audit dated for 01/08/2021 only reports no new skin alterations. Body audits dated 03/02/2021, 04/27/2021, 05/06/2021 revealed no measurements of wound to ankles and no weekly pressure injury records available. A weekly body audit dated 03/03/2021 revealed right and left ankles with both wounds measuring 1.0 cm x 1.0 cm with callous like wound on ankles. Three weekly skin reports provided by the DON revealed on 01/28/2021 Resident #5 had bilateral ankle abrasions with one measurement of 2.0 cm x 2.0 cm; on 03/15/2021 resident had non-pressure wounds to bilateral ankles, the wounds were facility acquired and a measurement of 2.0 cm x 2.0 cm one set of measurements for bilateral ankles; and on 04/13/2021 facility acquired non-pressure wounds to bilateral outer ankles and a measurement of 1.5 cm x 1.5 cm. Record review of Resident #6's Admission Record revealed the facility initially admitted Resident #6 on 07/31/2017 and readmitted on 01/16/2019 with the diagnoses of Cerebral Infarction, Atrial Fibrillation, High Blood Pressure, and anxiety disorder. The Admission Record revealed Resident #6 had an added diagnosis of Pressure ulcer Stage 2 to unspecified ankle on 05/07/2021. Record review of Resident #6's Annual MDS with ARD date 2/26/2021 Section M revealed Resident #6 had a Pressure ulcer of 1 or greater or a scar over a bony prominence. Section M had no other areas flagged for skin conditions. Resident #6's Quarterly MDS with ARD date 12/08/2020 Section M had no areas flagged for skin conditions. Resident #7	{M 735}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 735}	Continued From page 147 Record review of the Physician Order dated 07/07/20 and discontinued on 04/06/20 revealed Stage 3 to sacral/gluteal cleft cleanse with wound cleanser and pat dry apply puracol to wound bed, cover with Opti foam dressing daily. Review of a Physician Order dated 04/14/21 revealed cleanse sacral and hip wound with wound cleanser, pat dry, apply Aquacel Alginate foam pad apply to sacral and hip wound topically one time a day. Record review of Resident #7's Weekly Pressure Injury Records revealed one record dated 5/8/2021. There are no other records indicating evaluation or assessment of wounds for January 1, 2021, through May 8, 2021. Record review of Resident #7's Admission Record revealed the Facility initially admitted on 9/4/2018 and readmitted on 4/13/2021 with the following Medical Diagnoses include Type 2 Diabetes Mellitus, Heart Failure, Cardiomegaly, Cerebral Infarction, and Essential Hypertension. The Admission Record also revealed Resident #7 was diagnosed with Pseudomonas and Urinary Tract Infection 04/14/2021 and Sepsis on 04/13/2021. Record review of the Discharge Minimum Data Set (MDS) dated April 18, 2021, Section M of the MDS revealed Resident #7 had only one Stage 3 wound. Resident #12 Record review of Resident #12's Physician Orders revealed orders for A and D ointment to buttock topically two times a day with Nystatin and triamcinolone with start date 04/14/2021,	{M 735}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 735}	Continued From page 148	{M 735}		

hydrogel apply to Stage 2 buttock topically two times a day for decubitus buttock with a start date 12/31/2021, and a new order on 05/10/2021 for zinc oxide apply to buttocks. Resident also had order to send to the local wound care clinic every 2 weeks with start date 03/16/2021. An order with start date 01/01/2021 noted clean bilateral knees with normal saline, pat dry apply Promogran to wound beds, secure with border gauze and changer every 48 hours, and another order with start date 04/20/2021 cleanse wound to left and right anterior knee with normal saline, pat dry, apply Silvadene to wound bed and cover with a border dressing one time a day for wound care.

Record review of Resident's #12's TAR for April 2021 revealed omitted documentation for the treatment of bilateral lower extremities on 4/3/21 and 4/11/21 and omitted documentation for area to buttocks on 4/4/21, 4/7/21, 4/11/21, 4/20/21, 4/22/21, 4/23/21, 4/24/21, 4/28/21 and 4/29/21 for a total of eleven (11) entries omitted in April. Record review of the May TAR revealed omitted documentation for the treatment of buttocks on 5/2/21, 5/7/21, 5/8/21, and 5/9/21 for a total of four (4) entries omitted in May.

Record review of the Weekly Pressure Injury Record for Resident #12 revealed one record dated 4/19/2021 for area to right buttock.

There are no other records indicating evaluation or assessment of wounds for January 1, 2021, through May 8, 2021.

Record review of Admission Record revealed the facility initially admitted Resident #12 on 10/24/2021 and readmitted on 1/6/2021 with Medical Diagnoses of Unspecified Atrial Fibrillation, Peripheral Vascular Disease, Chronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 735}	Continued From page 149 Embolism, Morbid obesity, Pressure ulcer of right buttock Stage 2, Non-pressure chronic ulcers skin, Thrombosis of Unspecified Deep Veins of Unspecified Lower Extremity, Chronic Kidney Disease, and Essential Hypertension. Record review of the Quarterly Minimum Data Set (MDS) dated April 16, 2021, Section M of the MDS revealed Resident #12 had one Stage 2 ulcer. Resident #13 Record review of Resident #13's Physician Orders revealed order for heel protectors bilaterally due to skin breakdown on left heel start date 12/31/2020, betadine solution apply to left heel topically one time a day for 14 days started on 01/01/2021 and then restarted on 01/22/2021 for 10 days and then again on 02/02/2021. A new order for Santyl Ointment apply to left heel and cover with gauze dressing one time a day for wound care start on 03/03/2021. Another order to inspect resident feet daily started on 04/14/2021. Record review of Resident #13's medical records revealed the facility had no weekly pressure injury records for Resident #13 and there are no other records indicating evaluation of wounds from 01/01/2021 through 05/08/2021. Record review for Resident #13's Admission Record revealed the facility admitted Resident #13 initially on 04/04/2018 and readmitted on 11/30/2020 with diagnoses of Type 2 Diabetes Mellitus, High Blood Pressure, and Convulsions. The Admission Record revealed Resident #13 was diagnosed with Pressure ulcer of left heel Stage 2 on 04/16/2021.	{M 735}		

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	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 735}	Continued From page 150 Record review of Resident #13's Quarterly MDS with ARD date 04/28/2021, Section M revealed Resident #13 had one Stage 2 pressure ulcer. Resident #14 Record review of Resident #14's Physician Orders printed 05/10/2021 revealed orders for ensure hydrocolloid dressings are applied to left and right great toes and coccyx ulcers as ordered change dressings every 3 days and when visibility soiled as ordered date, initial, and time every dressing and document every dressing change in progress notes. The order was started on 01/10/2021 and discontinued on 03/15/2021 related to coccyx wound healed. An order was started on 03/16/2021 for ensure hydrocolloid dressings are applied to left and right great toes as ordered, change dressings every 3 days and when visibility soiled as ordered date, initial, and time every dressing and document every dressing change in progress notes, and inspect resident's feet daily every shift, an order was started on 12/13/2021 for Hydrocol pad apply to left and right 1st toes ulcers topically every 72 hours, change dressings every 3 days and when visibility soiled and order discontinued on 04/09/2021 resolved. Record review revealed that there are no records indicating assessment or measurement of wounds from January 1 through May 8, 2021. The Treatment Administration Record (TAR) Lacks documentation of application of Hydrogel and covering of Hydrocol Pad to left and right first toe ulcers on 3/13/21, 3/22/21 and 4/3/21. Record review of Resident #14's Admission Record revealed the facility initially admitted	{M 735}		

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	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 735}	Continued From page 151 Resident #14 on 05/20/2015 and readmitted on 08/14/2018 with the diagnoses of Hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side, Depressive disorder, Slurred speech, and Alzheimer's Disease. The Admission Record also revealed Resident #14 was diagnosed with Stage 2 pressure ulcer unspecified buttock 01/29/2021. Record review of Resident #14's Quarterly MDS with ARD date of March 1, 2021, Section M of the MDS revealed Resident #14 had no pressure, venous, or arterial ulcers, but did have moisture associated skin damage. Resident #17 Record review of Resident #17's Physician Orders from 03/01/2021 thru 05/31/2021 revealed an order dated 05/13/2021 cleanse sacral decubitus with ¼ strength Dakin's Solution, apply gentamicin sulfate powder to wound bed, pack wound with silver alginate, cut sponge to fit within wound bed, place wound vac at 125 pressure continuous suction change on Tuesday and Friday or sooner if there is suction malfunction, in case of wound vac malfunction, cleanse sacral decubitus with ¼ strength Dakin's solution, apply gentamicin sulfate powder to wound bed, pack wound with silver alginate and cover with bandage and notify provider. Stage 2 ulceration at site of urinary catheter insertion wound caused from pressure from the catheter, cleanse area with soap and water, dry, apply mixture of A and D ointment, Nystatin ointment, and triamcinolone cream daily, and wound care follow up at Field on 05/20/2021. Resident #17 had an order for body audit weekly and as needed. The Physician Orders revealed since Resident #17 had been admitted to the facility he has received oral,	{M 735}		

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	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 735}	Continued From page 152	{M 735}		

intramuscular, and intravenous antibiotics for wound infection, osteomyelitis, and gram-negative sepsis including Ceftriaxone 1 gram (gm) one time a day, Cipro tablet 500 milligram (mg) every 24 hours, clindamycin 300 mg, Levofloxacin 750mg/150 ml every 24 hours, Levofloxacin tablet 750 mg one time a day, and Meropenem 1 gm every eight hours.

Record review revealed missing documentation of wound care on the TAR for Hydrocel Gel to sacral wound on 03/28/2021, 04/03/2021, 04/11/2021; Providone-Iodine Solution to wounds to toes on 04/10/2021, 04/22/2021; Dakin's ¼ strength and hydrogel to sacral wound on 4/03/2021, 04/10/2021, 04/11/2021, 04/24/2021, and 04/29/2021.

Record review of weekly pressure injury records for Resident #17 revealed only four (4) weekly pressure reports for sacral wound dated 03/04/2021, 03/15/2021, 04/07/21, and 05/08/2021 in Resident #17's medical records. There were no other weekly pressure injury records provided by the facility.

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

Record review of Resident #17's 5-day Minimum Data Set (MDS) with ARD of March 12, 2021,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 735}	Continued From page 153 revealed Section M of the MDS revealed Resident #17 had one unstageable wound due to non-removable dressing/device and one unstageable wound due to slough or eschar, diabetic foot ulcer and other open lesions on the foot. On 5/5/2021 at 3:00 PM, in an interview with the DON, when asked if a treatment is not initialed what does that mean, she reported if it is not documented than it is not done. She further explained the treatments on the Treatment Administration Record should be initialed after the treatment is done. On 05/06/21 at 10:50 am interview with the DON, she explained she just started doing weekly wound care reports. She explained that she has not been consistent with doing wound reports. She explained the nurses on the med carts do the treatments and the measurements for each wound. 5-6-21 at 5:30 PM in an interview with the Nurse Consultant, she explained the DON has not been consistent with wound care reports for months. Removal Plan: The deficient practice consisted of missing and inaccurate documentation of wound care assessments, measurements, and care provided in the Medical Record. Noncompliance at F842 impacted Residents: #3, #5, #6, #7, #12, #13, #14, and #17. On 5/23/2021, the Director of Nursing was educated by the wound care-certified Regional Nurse Consultant (RNC) regarding the skin and wound care process, including documentation of wounds.	{M 735}		

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

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{M 735}	Continued From page 154 On 5/24/21, Corporate Management approved Wound Care Specialists from other facilities to work in the Facility to assist with Medical Record documentation. On 5/28/2021, the Certified Wound Care Nurse and MDS Coordinator assessed wounds for staging and treatment for Residents #3, #6, #7, #13, #14, and #17 to ensure correct treatments were implemented and that interventions were appropriate for the wounds identified. Any necessary changes identified in treatment and medications were reported to the Nurse Practitioner. Any new physician orders were entered, care plans were reviewed for needed revisions and revised according as orders were approved. Resident #12 discharged on 5/17/21. Beginning 5/28/21, the ADON/ICC, MDS Coordinator, and/or designee daily check nursing documentation entered into the Medical Record to ensure that no care is missed, and all care is documented. Beginning 5/28/21 and continuing, the ADON/ICC, Certified Wound Care Nurse and RNC educated all nursing staff (RNs, LPNs, CNAs) on the requirements of documentation of the following: wound measurements, Braden scale, notification of families about wounds and/or status of wounds, treatments provided, and written physician orders. The in-services were either in-person, in a classroom setting, or 1:1, either in person or by telephone. Any staff member not attending the initial in-service will be educated upon return and will not be permitted to work unless education is completed. Any staff member who fails to comply with the direction included in the in-services will be further educated and/or progressively disciplined. On 6/1/21 and 6/2/21, the Certified Wound Care Nurse, MDS Coordinator, and ADON/ICC conducted an audit of all other resident's charts	{M 735}		

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{M 735}	Continued From page 155	{M 735}		

for missed documentation, such as any skin assessments or any treatments not documented. All residents' comprehensive care plans were also checked for potential skin issues and were updated based on findings from the assessments. Beginning 6/03/21, an additional Certified Wound Care Nurse began auditing all residents for a new complete skin assessment. Any additional areas noted were communicated to the provider for new or revised orders.
Validation:
The validations do not include Residents #5 due to resident being discharged.
The State Survey Agency (SSA) validated through review of In-Service sign-in sheets, the Director of Nursing (DON) was educated by the Wound Care Certified Regional Nurse Consultant regarding skin and wound care process, including documentation of wounds.
The SSA validated through staff interviews a Wound Care Specialist from another facility that he is currently working on site at the Facility to assist with Medical Record Documentation until a Certified Wound Care nurse is hired.
The SSA validated through staff interviews and review of Weekly Pressure Injury Records for Residents #3, #6, #7, #13, #14, and #17, wounds for Residents #3, #6, #7, #13, #14, and #17 were assessed for staging and treatment by the Certified Wound Care Specialist to ensure correct treatments were implemented and that interventions were appropriate for wounds and necessary changes identified were reported to Nurse Practitioner and new order entered.
The SSA validated through staff interviews and review of Medical Records Job Duties Form revealed the Medical Record Nurse has been designated by the ADON/ICC and MDS Coordinator to complete daily checks for nursing documentation. The task of completing the daily

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	03AC	A. BUILDING: _____ B. WING _____	R-C 06/17/2021

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

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{M 735}	Continued From page 156	{M 735}		

checks of nursing documentation was added to the Medical Records list of duties.
The SSA validated through staff interviews and reviews of In-Service sign-in sheets, the ADON, Certified Wound Care Nurse, and Regional Nurse Consultant educated all nursing staff on requirements of documentation of the following: wound measurements, Braden scale, notification of families about wounds and/or status of wounds, treatments provided, and written physician orders. The in-services were either in-person, in a classroom setting, one on one, or via phone. Any staff not attending the in-services will not be permitted to work unless education is completed. An interview with the ADON verified no staff member has failed to comply with the in-services.
The SSA validated through staff interviews and record reviews of Medication Administration Record and Treatment Administration Record audits revealed the facility completed audits of all resident's charts for missing documentation.
The SSA validated through staff interviews and record reviews of residents' care plan the facility audited and updated care plans for skin issues.
The SSA validated through staff interviews with the Certified Wound Care Nurse and ADON/ICC and review of body auditing tools, individual resident body audit forms, and Comprehensive Care Plans, the ADON/ICC completed audits on all resident charts for missing documentation, including skin assessments or treatments. The MDS Coordinator verified all residents' Comprehensive Care Plans were audited and updated based on the findings from the audit.
The Certified Wound care Nurse verified the completion of skin assessments for all residents on census. The physician was notified of any new issues.