

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  255271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/22/2024
NAME OF PROVIDER OR SUPPLIER  Liberty Community Living Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  323 Industrial Park Drive Liberty, MS 39645	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>47873</p> <p>48181</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to assist a resident with eating in a dignified manner during a dining observation, as evidenced by a Certified Nurse Aide (CNA) was observed standing over a resident while assisting the resident to eat during one (1) of two (2) meal observations. Resident #21</p> <p>Findings Include:</p> <p>A review of the facility's policy titled Resident Rights, revised and implemented 11/28/16, revealed, .The resident has a right to a dignified existence .A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident .</p> <p>On 08/22/24 at 8:50 AM, during a dining observation, CNA #1 was observed standing while feeding Resident #21.</p> <p>On 08/22/24 at 9:05 AM, during an interview, CNA #1 acknowledged she was standing while feeding Resident #21. CNA #1 stated she was aware the proper way to assist a resident with feeding is to sit. CNA #1 reported she was not trained to sit during assisted feeding at this facility but had learned the importance of sitting while assisting residents while eating from her years of experience as a CNA.</p> <p>On 08/22/24 at 9:16 AM, during an interview, the Director of Nursing (DON) stated that CNAs are trained to position themselves in front of the residents, observe, and make eye contact during assisted feeding. The DON reported that the staff should not be standing while feeding but may sit depending on the resident's level. The DON confirmed that her expectation is to ensure the staff are trained to sit while performing assisted feedings.</p> <p>On 08/22/24 at 12:52 PM, during an interview, the Administrator acknowledged that a staff member had assisted the resident in feeding while standing. The Administrator stated that the staff would be in-serviced on the proper way to assist the residents in feeding.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of the facility's Admission Record revealed the facility admitted Resident #21 on 12/28/17. The resident's diagnoses included Vascular Dementia, Unspecified Severity, with Other Behavioral Disturbances, and Dysphagia, Pharyngoesophageal Phase.</p> <p>A record review of Resident #21's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/29/24 revealed a Brief Interview for Mental Status (BIMS) should not be conducted. Further review revealed the staff's assessment of the resident's cognitive status indicated the resident was severely impaired regarding cognitive skills for daily decision making.</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41680</b></p> <p>Based on record review, staff interviews, and facility policy review the facility failed to provide the Notice of Medicare Non-Coverage letter indicating the resident was notified prior to Medicare coverage ending for two (2) of three (3) residents reviewed for beneficiary protection notification. (Resident #12 and Resident #34)</p> <p>Findings Include:</p> <p>Review of the facility's policy titled, Medicare Advanced Beneficiary Notice, with a review date of 7/24/23, revealed Residents are informed in advance when changes will occur in their bills. If the interdisciplinary team believes (upon admission or during the resident stay) that Medicare (Part A of the fee for service Medicare Program) will not pay for an otherwise covered skilled service(s), the resident (or representative) is notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s) .</p> <p>Resident #12</p> <p>Record review of the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review with a start date of 1/30/24 revealed last covered day of Part A Service was 2/22/24. However, the resident has remained in the facility.</p> <p>Record review Resident #12's Advance Beneficiary Notice of Non-coverage revealed the last covered treatment was 5/31/24. This document was not dated or signed by the resident or Resident Representative (RR).</p> <p>Review of the Admission Record of Resident #12 revealed the facility admitted the resident to the facility on [DATE]. The resident's diagnoses included Chronic Obstructive Pulmonary Disease, Parkinson's Disease, without Dyskinesia, and Heart Failure.</p> <p>Resident #34</p> <p>Record review of the SNF Beneficiary Protection Notification Review with a start date of 2/5/24 revealed last covered day of Part A Service was 3/1/24.</p> <p>Record review Resident #34's Advance Beneficiary Notice of Non-coverage revealed the last covered treatment was 4/10/24. This document was not dated or signed by the resident or RR.</p> <p>Review of the Admission Record for Resident #34 revealed the facility admitted the resident to the facility on [DATE]. The resident's diagnoses included Malignant Neoplasm of Unspecified Part of Unspecified Bronchus or Lung and Adult Failure to Thrive.</p> <p>(continued on next page)</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/22/24 at 11:12 AM, in an interview with the Business Office Manager/Human Resources staff she stated she started working at the facility 8/12/24 and has had previous experience and knowledge of completing the Beneficiary Forms. She stated the forms are reviewed with the resident or RR a week before coverage ends and at that time, she gets them to sign it showing that they were informed. She stated the reason for it is to let the resident and the family know their options. She stated it should always be signed, it shows they were informed of options and coverage. She stated if the RR did not come to the facility, she would send it in a certified letter for them to sign upon receipt.</p> <p>On 8/22/24 at 12:49 PM, in an interview the Administrator he stated he became aware of the notices not being done according to policy upon the State Agency (SA) entrance to the facility. He stated he has already put things in place so that it will not happen again. He stated he expects his staff to follow policy.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47873</b></p> <p>Based on observations and staff interviews, the facility failed to store and date respiratory equipment in a manner that prevented possible cross-contamination and consistent with professional standards of practice, as evidenced by, undated tubing and a face mask not being bagged when not in use, for two (2) of four (4) observations. Resident #171.</p> <p>Findings Include:</p> <p>A record review of the facility's Oxygen Administration policy, dated August 25, 2014, revealed Purpose: The purpose of the procedure was to provide guidelines for safe oxygen administration . The policy did not address handling and storage of oxygen tubing.</p> <p>On 08/19/24 at 11:41 AM, an observation of Resident #171 revealed that the oxygen tubing attached to the resident was not dated, and the face mask, which was not in use, was hanging from the wall and not placed in a bag.</p> <p>On 08/20/24 at 8:50 AM, during an observation revealed the oxygen tubing attached to Resident #171 remained undated, and the face mask, still not in use, continued to hang from the wall without being bagged.</p> <p>Record review of Resident #171's Order Summary Report with active orders as of 8/22/24, revealed an order dated 7/23/24 O2 (oxygen) BNC (by nasal cannula) at 4 LPM (liters per minute) cont. (continuously) every shift related to Chronic Obstructive Pulmonary Disease with Acute Exacerbation (J44.1).</p> <p>Record review of an order dated 3/11/24 revealed BiPAP (Bilevel Positive Airway Pressure) QHS (every hour of sleep) and PRN (as needed) .related to Chronic Obstructive Pulmonary Disease .</p> <p>A record review of Resident #171's Admission Record revealed the facility admitted the resident on 05/29/24, with an original admitted [DATE], and the resident had diagnoses including Chronic Obstructive Pulmonary Disease with Acute Exacerbation and Chronic Systolic (Congestive) Heart Failure.</p> <p>On 08/20/24 at 9:36 AM, during an interview, Licensed Practical Nurse (LPN) #1 stated the facility's policy requires replacing all respiratory tubing weekly, and the tubing should be dated and stored in a dated plastic bag when not in use. She mentioned that she had never seen a bag for storing the tubing since she began working at the facility.</p> <p>On 08/20/24 at 10:36 AM, during an interview, Assistant Director of Nursing (ADON) stated that nurses should review the oxygen tubing policy if unsure of the correct procedures. She confirmed that tubing is supposed to be changed weekly and turned off when not in use. She emphasized that the policy is in place to decrease the risk of potential or direct exposure to infectious diseases, air contaminants, and bacterial exposure. She stated that it is ultimately the responsibility of all nurses caring for residents on oxygen therapy.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/20/24 at 11:20 AM, during an interview, the Director of Nursing (DON) stated that both she and the ADON educate nurses on the care of oxygen tubing. She mentioned that new employees receive a copy of the policy and procedures on changing oxygen tubing and keeping it in a bag when not in use. The DON confirmed that it is the cart nurse's responsibility to change, label, and care for oxygen/nebulization tubing, with the tubing usually being changed on the Sunday night/Monday morning shift.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48181</b></p> <p>Based on observation, interviews, and facility policy review, the facility failed to store food in accordance with professional standards for food service safety related to food items not dated, exposed foods, and expired foods in one (1) of two (2) kitchen observations.</p> <p>Findings Include:</p> <p>A review of the facility's policy titled Labeling and Dating for Safe Storage of Food, revised [DATE], revealed . All products should be dated when opened . Use Use-By dates on all food once opened . When food is taken out of an original container . write . the Use-By date .</p> <p>The facility did not provide a policy that specifically addressed exposed food products.</p> <p>On [DATE] at 10:31 AM, an observation of the kitchen revealed Refrigerator #1, revealed the following: one (1) 46-ounce carton of orange juice with an open on date of [DATE] and a manufacturer's best if used by date of [DATE]; one (1) opened gallon of 1 percent milk with a manufacturer's best by date of [DATE] and a facility date of [DATE] with no indication of what the date meant; and one (1) five (5)-pound tub of pimento cheese spread with a facility opened on date of ,d+[DATE] and a manufacturer's use by date of [DATE]. An observation of Refrigerator #2 revealed the following: four (4) unopened gallons of whole milk with a manufacturer's best by date of [DATE]; one (1) plastic storage bag of cheese slices with the date rubbed off, leaving the date illegible; one (1) container of leftover beef and gravy with a facility use by date of [DATE]; and one (1) container of leftover rice with a facility use by date of [DATE]. An observation of the freezer revealed seven (7) four (4)-ounce cups of rainbow sherbet containing dairy that had been removed from the original box and had no date. An observation of the pantry revealed one (1) box of tea bags not individually wrapped, with the tea bags exposed. The dry bins revealed the lid on the sugar bin was not securely on the bin, leaving the sugar exposed.</p> <p>On [DATE] at 10:31 AM, during an interview, the Dietary Supervisor (DS) acknowledged the outdated, exposed, and undated foods. The DS stated it was her responsibility to monitor the foods for expiration dates and quality. She reported that it was the responsibility of the staff who opened the food item to write an opened on date on the food package. The DS further explained that she in-serviced the staff on kitchen safety once a month.</p> <p>On [DATE] at 12:52 PM, during an interview, the Administrator acknowledged he had been made aware of the expired, exposed, and undated food items that had been observed during the kitchen observation. The Administrator reported that his expectation was for the kitchen staff to regularly check the food, ensuring that foods are dated, labeled, and expired foods are removed from the kitchen.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41680</p> <p>Based on observations, interviews and facility policy review the facility failed to prevent the potential for the spread of infection as evidenced by, facility staff observed transporting linen in an unsanitary manner for two (2) of six (6) hall observations.</p> <p>Findings Include:</p> <p>Review of the facility's policy titled, Departmental (Environment Services) - Laundry and Linen, revised August 2009, revealed .The purpose of this procedure is to provide a process for the safe and aseptic handling, washing and storage of linen . In Resident Rooms 1. Do not allow linen clean or soiled to touch clothing or uniform. 2. Handle all linen as though it is potentially infectious .</p> <p>On 08/21/24 at 10:20 AM, an observation of Certified Nursing Assistant (CNA) #2 revealed the CNA hugging clean linen to her uniform going down the 400 hall and placing it on the laundry cart in the hallway. The laundry consisted of bed linen, towels and pads.</p> <p>On 08/21/24 at 1:57 PM, in an interview with CNA #2, she stated she had 2 towels, 2 fitted sheets and 2 pads. She stated she was not paying attention to how she carried the laundry. She confirmed that her actions contaminated the laundry by carrying it against her uniform.</p> <p>On 08/21/24 at 12:54, CNA #1 was observed carrying 2 towels wrapped up in her arms against her uniform down the 100 hall.</p> <p>On 08/21/24 at 2:12 PM, in an interview with CNA #1 stated she was moving fast and was not thinking. She stated carrying the towels next to her uniform contaminated the towels. She stated she has been trained to carry the linen away from her uniform, she just forgot.</p> <p>On 08/21/24 at 2:20 PM, in an interview the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) stated staff are supposed to transport clean and dirty laundry in a bag away from their uniform. She stated the uniform is considered dirty and by holding clean linen against their uniform, they contaminated the clean laundry, which could spread infection.</p> <p>On 08/22/24 at 12:56 PM, in an interview, the Administrator stated he expects the CNAs to follow policy when transporting linen.</p> <p>47873</p>		