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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Community Living Ctr	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility policy review, the facility failed to ensure food items were stored, dated, and maintained in accordance with professional food safety standards for one (1) of three (3) kitchen observations.Findings include:A review of the facility's Food Storage Areas Policy and Procedures, undated, revealed, .Dry storage areas will be kept in a condition which protects foods from infestation. Procedure: 1. All items must be stored at least 6 inches off the floor .Care of the Storeroom [ROOM NUMBER]. The staff will maintain care of the storeroom according to the following directions.b. New stock is placed in back of previously delivered items so that older stock will be issued first. C. Refrigerated and frozen foods are dated upon delivery. Foods with expiration dates are used prior to date on the package.On 12/1/25 at 10:30 AM, during an observation of the kitchen with the Dietary Manager (DM), the dry storage room contained two (2) dry storage bins holding rice and sugar that were not dated. A twenty-five (25) pound bag of [NAME] sugar and a twelve (12) pound bag of [NAME] coffee were stored directly on the floor. A sugar-free no-bake cheesecake mix and a box of powdered sugar were observed opened and stored in clear Ziploc bags without labels or dates. Nine (9) [NAME] Monte bananas stored in a box were black with dark brown spots; one banana was split open, black, and mushy. In the refrigerator, fifty (50) single-serve Hiland chocolate milk cartons were dated 10/27/25, and twenty (20) cartons were dated 11/20/25. Seventy-six (76) single-serve Daily sour cream packs stored in two brown boxes were dated 3/5/25.On 12/1/25 at 10:55 AM, during an interview with the DM, she acknowledged the expired chocolate milk and sour cream should have been discarded on the expiration date. She explained that serving expired dairy products could result in residents developing gastrointestinal illness. She reported she was responsible for checking behind dietary staff. She confirmed that no food items should be stored on the floor, that all refrigerated items should be labeled and dated, that the bananas should have been discarded, and that dry storage bins were required to be dated. She explained the purpose of dating and labeling food items was to prevent spoiled food from being served to residents.On 12/4/25 at 1:25 PM, during an interview, the Nursing Home Administrator (NHA) explained she expected the Dietary Department to follow facility policy and regulatory requirements to ensure resident safety. The NHA reported she expected dietary staff to rotate stock daily and remove all expired food items from the kitchen.

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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Community Living Ctr	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)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observation, interview, record review, and facility policy review, the facility failed to provide an ongoing program of individualized activities to meet the physical, mental, and psychosocial needs of residents residing on the Dementia Unit for two (2) of two (2) sampled residents reviewed on the Alzheimer's Unit (Residents #9 and #63), with the potential to affect all nineteen (19) residents on the unit.Findings include: A review of the facility's, Life Connections Program, revised May 4, 2021, revealed, Policy .Procedures. Life Connection Programs should be designed as an ongoing resident-centered activities program that incorporates the residents' interests . Life Connections activity may be scheduled seven (7) days a week . Specialized activities will be available for residents with cognitive impairment .Resident #9A record review of the admission record revealed the facility admitted Resident #9 on 4/5/23 with diagnoses including Vascular Dementia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/30/25 revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated her cognition was moderately impaired.Resident #63A record review of the admission record revealed the facility admitted Resident #63 on 4/6/22 with diagnoses including Unspecified Dementia.A record review of the Quarterly MDS with an ARD of 9/18/25 revealed Resident #63 had a BIMS score of 3, which indicated her cognition was severely impaired.On 12/1/25 at 10:20 AM, during an observation of the Alzheimer's Unit dayroom, there were no activities in progress and many of the residents were sitting in the dayroom with the television on.On 12/3/25 at 12:07 PM, during an observation and interviews on the Alzheimer's Unit, the residents, including Residents #9 and #63, were seated in the dining hall eating lunch. No music or other sensory engagement was provided. Certified Nursing Assistant (CNA) #1 stated many residents had requested music during meals and that the unit's CD player had been removed some time ago. CNA #1 reported she had requested a replacement from administration, but none had been provided. Resident #9 stated music brought her peace when she was growing up and she desired it now more than ever. Resident #63 stated the residents needed music because it was soothing.On 12/3/25 at 12:46 PM, during an observation of the unit activity board and interview with Resident #9, there were two calendars posted, in which one was designated for daytime activities and one for evening activities. Neither calendar listed any times for when the activities would occur. The 12/3/25 Day calendar listed This Day in History, and the 12/3/25 Evening calendar listed Matching Cards, both without scheduled times. Resident #9 stated she did not know what This Day in History was and reported the only activity provided was watching television. She added that staff do not come to interact with them, nor do they perform the activities listed on the calendar.A record review of the Activity Calendar for December revealed a calendar for Morning Activities and Evening Activities with one activity listed per date and no specified time the activity was scheduled.On 12/3/25 at 12:48 PM, during an interview with CNA #1, she reported that no one comes to the unit to provide activities and that residents wake, eat, watch television, and sleep. She explained that the residents need some type of additional engagement, something that stimulates them, and commented that just because they have dementia, that does not mean they would not enjoy activities.On 12/3/25 at 12:51 PM, during an interview with CNA #2, she reported that although an activity calendar is posted, no activities are provided and residents remain in the dayroom watching television. She confirmed that no one from the activities department had come to the unit that day.On 12/3/25 at 1:00 PM, during an interview with Registered Nurse (RN) #1, Dementia Unit Manager, she confirmed that activities were not being provided on the unit. On 12/4/25 at 10:36 AM, during an interview with the Activities Assistant Coordinator, he confirmed he was responsible for Dementia Unit activities and acknowledged that many scheduled activities had not been conducted. He stated he was often assigned to other duties that prevented him from completing activities.On 12/4/25 at approximately 10:41 AM, during an interview with the Director of Nursing (DON), she stated she had identified that activities were not consistently provided on the Dementia Unit and had instructed the (continued on next page)

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Community Living Ctr	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)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Activities Assistant Coordinator to conduct activities daily.On 12/4/25 at 10:57 AM, during an interview with the Administrator, she reported she was not aware that activities were not being conducted. She stated it was regulatory for residents to have activities every hour on the hour. She stated music was important to creating a pleasant environment and residents should have music when desired.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Community Living Ctr	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)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent recurrence of a previously cited deficiency, specifically, the facility was cited for failing to store food in accordance with professional standards for food service safety related to food items not dated, exposed foods, and expired foods during an annual recertification survey on 8/22/24 and was cited again for the same deficiency during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of ten (10) deficiencies cited. F812 Findings include:A review of the facility's, QAPI Plan, undated, revealed, .Aspects of service and care are measured against established performance goals. Key performance indicators are measured and trended on a quarterly basis. The QAPI Committee analyzes performance to identify and follow-up on areas of opportunity. The facility will utilize the best available evidence.to define and measure goals. The facility continually identifies opportunities for improvement and reviews the following areas to prioritize opportunities .Record review of the Provider History Report revealed the facility received a citation for F812 - Food Procurement, Store/Prepare/Serve-Sanitary with a Plan/Date of Correction of 10/18/2024.Record review of the CMS-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date 8/22/24, revealed the facility received a citation for F812, .Based on observation, interviews, and facility policy review, the facility failed to store food in accordance with professional standards for food service safety related to food items not dated, exposed foods, and expired foods in one (1) of two (2) kitchen observations.During the current recertification survey, the facility failed to ensure food items were stored, dated, and maintained in accordance with professional food safety standards for one (1) of three (3) kitchen observations.On 12/4/25 at 10:57 AM, during an interview with the Administrator, she stated she was unsure why the dietary department was cited again. During her meetings with the Dietary Manager, she indicated that everything was labeled and dated, and there were no expired foods on the shelves.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Community Living Ctr	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review, and facility policy review, the facility failed to implement care plan interventions related to oral hygiene (Resident #57) and Percutaneous Endoscopic Gastrostomy (PEG) care (Resident #70) for two (2) of 19 sampled residents. Findings Include:A review of the facility's Care Plan Policy and Procedure, undated, revealed, .Each resident's care plan will remain current and inform staff of resident's needs.Resident #57A record review of the admission Record revealed the facility admitted Resident #57 on 2/14/25 with diagnoses including Need for Assistance with Personal Care. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/25 revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated her cognition was severely impaired.A record review of the Care Plan Report revealed Resident #57 had a care plan Focus of (Proper name of Resident) has an ADL self-care performance deficit. with Interventions/Tasks including Oral hygiene: setup/clean x's (times) 1 person assist.During an observation and interview on 12/1/25 at 2:29 PM, Resident #57 was lying in bed and reported she did not receive mouth care daily. She had visible discoloration and debris on her teeth. During an observation and interview on 12/3/25 at 3:23 PM, Resident #57 was in her room with her spouse present. Resident #57 explained that her teeth had not been brushed that day and her teeth had visible discoloration and she had a mouth odor.During an observation and interview on 12/3/25 at 3:50 PM, during an observation and subsequent interview, CNA #5 confirmed that Resident #57 had visible discoloration and debris on her teeth. She reported she brushed Resident #57's teeth that day but acknowledged she should have provided oral care more than once and further explained that Resident #57's teeth should be brushed after every meal.Resident #70A record review of the admission Record revealed the facility admitted Resident #70 on 2/11/25 with diagnoses including Dysphagia.A record review of the Order Summary Report revealed Resident #70 had a Physician's Order, dated 2/11/25 to clean the Percutaneous Endoscopic Gastrostomy (PEG) site daily with warm soap and water.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/30/25 revealed Resident #70 required a staff assessment for mental status and that her cognitive skills for daily decision making was severely impaired. A record review of the Care Plan Report revealed Resident #70 had a care plan Focus of (Proper Name of Resident) has PEG tube to upper mid abdomen. with Interventions/Tasks of Clean peg site daily with warm soap and water cover with dry dressing every day.During an observation of PEG tube care on 2/3/25 at 2:05 PM, Licensed Practical Nurse (LPN) #2 removed Resident #70's PEG tube dressing and cleaned only the external PEG tubing with soap and water. She dried the tubing with a dry gauze. The LPN did not clean the PEG tube insertion site.During an interview on 12/3/25 at 3:28 PM, LPN #2 she confirmed that not cleaning the PEG insertion site could cause residue to build up around the entry site and cause an infection.During an interview on 12/4/25 at 11:56 AM, LPN #3/Care Plan nurse explained that care plan interventions are to be used by staff to provide care as it focuses on patient care. During an interview on 12/04/2025 at 12:10 PM, the Director of Nursing (DON) stated she expected staff to provide care according to the resident's care plan.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Community Living Ctr	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, record review, and facility policy review, the facility failed to ensure Activities of Daily Living (ADL) care, including oral hygiene was provided for one (1) of one resident who required staff assistance with oral care, Resident #57.Findings include:A review of the facility's ADL Care of A Resident Policy And Procedure, undated, revealed .Resident ADL care will be provided to the resident according to the individualized resident needs .A record review of the admission Record revealed the facility admitted Resident #57 on 2/14/25 with diagnoses including Need for Assistance with Personal Care. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/25 revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated her cognition was severely impaired.On 12/1/25 at 2:29 PM, during an observation and interview with Resident #57, the resident was lying in bed and reported she did not receive mouth care daily. She explained that when she requested oral care, staff told her they would return but did not do so. She reported her teeth were previously white and had become stained. An observation of Resident #57's mouth revealed visible discoloration and debris on the teeth. She reported the last time she received oral care was the prior Wednesday or Thursday.On 12/2/25 at 3:30 PM, during an observation of Resident #57 lying in bed, the resident reported she had been in bed most of the day and had not had mouth care that week.On 12/3/25 at 3:23 PM, during an observation and interview with Resident #57 at bedside with her spouse present, the resident reported her teeth had not been brushed that day. An observation revealed visible discoloration and mouth odor.On 12/3/25 at 3:45 PM, during an interview with Certified Nursing Assistant (CNA) #5, the CNA reported she was assigned to Resident #57 that day and had provided a bed bath and brushed the resident's teeth once. She explained Resident #57's teeth should be brushed after every meal.On 12/3/25 at 3:50 PM, during an observation and subsequent interview, CNA #5 confirmed that Resident #57 had visible discoloration and debris on the teeth. She reported she brushed Resident #57's teeth that day but acknowledged she should have provided oral care more than once.On 12/3/25 at 4:00 PM, during an interview with the Director of Nursing (DON), she explained that visible buildup on teeth develops over time and not within a few days. She reported her expectation was that Certified Nursing Assistants provide daily oral care, personal care, and hygiene according to individual resident needs.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Community Living Ctr	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)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, record review, and facility policy review, the facility failed to provide care and services in a manner to prevent complications for one (1) of three (3) residents reviewed for tube feeding and nutrition, Resident #70.Findings include:A review of the facility's Enteral Feeding Tube - Care of Procedure, undated, revealed, .Purpose: to prevent irritation and skin breakdown around feeding tube.Procedure.4. Clean skin around tube with warm water and soap or wound cleaner.A record review of the admission Record revealed the facility admitted Resident #70 on 2/11/25 with diagnoses including Dysphagia.A record review of the Order Summary Report revealed Resident #70 had a Physician's Order, dated 2/11/25 to clean the Percutaneous Endoscopic Gastrostomy (PEG) site daily with warm soap and water.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/30/25 revealed Resident #70 required a staff assessment for mental status and that her cognitive skills for daily decision making was severely impaired. On 12/3/25 at 2:05 PM, during an observation of PEG tube care performed by Licensed Practical Nurse (LPN) #2 for Resident #70, the LPN removed the PEG tube dressing and cleaned only the external PEG tubing by wiping from bottom to top on each side using gauze saturated with soap and water. She dried the tubing with a dry gauze. The LPN did not clean the PEG tube insertion site.On 12/3/25 at 3:28 PM, during an interview with LPN #2, she confirmed that not cleaning the PEG insertion site could cause residue to build up around the entry site and cause an infection.On 12/3/25 at 4:10 PM, during an interview with the Director of Nursing (DON), she stated the purpose of cleaning the PEG site correctly was to prevent infection. She reported the manner in which LPN #2 performed PEG care could cause infection and presented a cross-contamination issue.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Community Living Ctr	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Level IIBased on observation, interview, record review, and facility policy review, the facility failed to ensure medications and biologicals were securely stored and properly labeled when a controlled substance returned by a resident was left unlabeled on a medication cart and when a wound care cart containing treatment chemicals was unlocked and accessible to residents for two (2) of three (3) medication/treatment carts reviewed. Findings Include:A review of the facility's Medication Storage Policy and Procedure, undated, revealed, .Policy: 1. Medications and biologicals will be maintained in a secured location only accessible to designated staff.On 12/2/25 at 1:33 PM, during an observation of a medication cart with Licensed Practical Nurse (LPN) #1, a loose pill was noted in a clear plastic sleeve labeled 12 PM but without the resident's name, drug name, strength, dosage, or any identifying information. LPN #1 identified the pill as Oxycodone-Acetaminophen Tablet 5-325 milligrams (mg) that Resident #10 had checked out when leaving the facility on pass and returned that morning. The pill had been placed on the cart without a label and without secure storage.On 12/2/25 at 1:35 PM, during an interview with LPN #1, she reported she placed the medication on the cart after the resident returned it and planned to notify the night nurse during shift report. When asked how other nurses would know what the medication was, she acknowledged they would not and confirmed that the medication could be administered in error or diverted since it was unlabeled and unsecured. She stated she should have asked the Director of Nursing (DON) how to handle the medication upon return.On 12/3/25 at 2:18 PM, during an observation and interview with LPN #2, the wound care cart on the 400 hall was observed. Although the cart appeared locked, with the lock pushed inward, all drawers opened freely. The cart contained wound treatment supplies including triple antibiotic ointment, calamine lotion, MediHoney, and Nystatin powder. LPN #2 confirmed she believed the cart was locked but realized it was fully accessible and acknowledged that residents, including cognitively impaired residents, could access the unsecured chemicals.On 12/4/25 at 9:27 AM, during an interview with the DON, she stated the returned Oxycodone 5 mg tablet for Resident #10 should have been destroyed by two nurses per facility policy and should not have been left on the medication cart. She explained the risks included medication error or diversion since the pill was unlabeled and unaccounted for. Regarding the wound care cart, the DON stated the cart had been unable to lock since September 2025 and should not have been stored on the hallway. She explained the interim process was for staff to pull treatments from the cart and store supplies in the medication room. The DON confirmed residents could ingest wound chemicals if the cart remained unlocked and acknowledged that wandering residents lived on the unit. The DON provided documentation showing the facility received a quote for a new cart on 9/12/25 and ordered a replacement on 11/18/25.A record review of the admission Record revealed the facility admitted Resident #10 on 10/12/25, with diagnoses including Quadriplegia. A record review of the Order Summary Report revealed Resident #10 had a Physician's Order, dated 10/10/24 for Oxycodone-Acetaminophen Tablet 5-325 milligrams.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Community Living Ctr	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)
F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on observation, interview, and record review, the facility failed to ensure a resident received a diet and follow-up dental care consistent with the resident's nutritional needs and edentulous status when the resident remained without dentures for over two (2) months and continued to receive regular-texture meals for one (1) of nineteen (19) sampled residents (Resident #76).Findings Include:On 12/01/2025 at 1:50 PM, in an interview, Resident #76 stated his teeth had been lost in the laundry. The facility had taken him to a dentist about a month ago for a fitting, but he had not heard anything further about replacement dentures.On 12/03/2025 at 12:35 PM, an interview and observation of Resident #76 revealed he had a lunch tray consisting of fried chicken, green beans, mashed potatoes, and cornbread. He reported difficulty chewing the meat without his teeth and stated that meals often included pork chops or other tough meats. He expressed that it was hard for him to cut and swallow food without dentures. The tray was identified as a regular diet with no accommodation for edentulism.On 12/04/2025 at 10:30 AM, in an interview with Resident #76's Certified Nurse Aide (CNA) #6, she stated that the resident feeds himself but frequently complains that meat on his tray is hard to chew. She confirmed he is receiving a regular diet and stated that he could probably benefit from an easier diet for people with no teeth. She further reported that she was aware he had an appointment for dentures a few months ago.On 12/04/2025 at 10:50 AM, in a phone interview with the receptionist at the dental office, she confirmed Resident #76 was seen on 09/11/2025 for an initial evaluation and limited x-ray, but was not fitted for dentures at that time. She stated there had been no follow-up from the facility, and as of 12/04/2025, he had not returned. She explained that the full denture process typically takes approximately two months and that the resident could have had his dentures by mid-November if the process had continued appropriately.On 12/04/2025 at 12:14 PM, in an interview with the Director of Nursing (DON), she confirmed that she was unaware the resident had not returned for a follow-up visit since the initial appointment in September. She explained that the transportation CNA is responsible for notifying the DON or nursing team after appointments and making arrangements for any required follow-up. She confirmed this did not occur for Resident #76.On 12/04/2025 at 2:07 PM, in an interview with the Administrator, she confirmed that the resident had not returned to the dental provider and that she personally contacted the office on 12/04/2025 to schedule a follow-up once she became aware. She stated the resident now has a same-day appointment.A record review of the admission Record revealed the facility initially admitted Resident #76 on 9/18/24 with diagnoses including Type 2 Diabetes Mellitus. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/10/2025 indicated Resident #76 had a Brief Interview for Mental Status (BIMS) score of 9, reflecting moderate cognitive impairment.A record review of the Order Summary Report revealed Resident #76 had a Physician's Order, dated 9/18/24, for a Regular diet, Regular texture, Regular consistency.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Community Living Ctr	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility policy review, the facility failed to implement appropriate infection prevention and control practices during indwelling catheter care (Resident #6), and failed to follow hand hygiene, glove-use, surface sanitation, and Enhanced Barrier Precautions (EBP) requirements during enteral feeding tube care (Resident #70) for two (2) of three (3) residents reviewed for care. Findings include: A review of the facility's Hand Hygiene Policy and Procedure, dated 4/11/23, revealed, .Hand hygiene will be performed by all staff consistent with accepted standards of practice, to reduce the spread of infection and prevent cross contamination. A review of the facility's Isolation Policy and Procedure, undated, revealed, .Enhanced Barrier Precautions (EBP): 1. EBP Precautions are utilized for residents that have wounds and/or indwelling medical devices (Central line Catheter, feeding tube.).2. PPE (Gloves and gown prior to the high-contact care activity) is to be utilized.during high-contact resident care activities.g. Device care or use (Central line, urinary catheter, feeding tube.). Resident #6 On 12/2/25 at 1:50 PM, during an observation of catheter care performed by Certified Nursing Assistant (CNA) #3 for Resident #6, CNA #3 washed the soiled catheter tubing, rinsed it, and patted it dry while continuously wearing the same gloves. She then touched the resident's shoulder and thigh to reposition him without removing gloves or performing hand hygiene. On 12/2/25 at 1:55 PM, during an observation of perineal care provided by CNA #4 for Resident #6, CNA #4 removed a soiled brief after a bowel movement while wearing gloves and then used the bed remote with the same soiled gloves, contaminating environmental surfaces. On 12/2/25 at 1:56 PM, during an interview with CNA #4, she confirmed she should have removed soiled gloves and performed hand hygiene prior to touching environmental surfaces. She acknowledged the risk of spreading infections. On 12/2/25 at 2:01 PM, during an interview with CNA #3, she confirmed she should have removed gloves, performed hand hygiene, and reapplied clean gloves prior to repositioning Resident #6. She acknowledged the potential for the spread of infection from the catheter area. On 12/4/25 at 9:30 AM, during an interview with the Director of Nursing (DON), she stated her expectation was that staff change gloves and perform hand hygiene after each care task. The DON reported that CNA #3 could have spread infection from the catheter area and CNA #4 could have spread infection from fecal matter to surfaces in the resident's room. A record review of the admission Record revealed the facility admitted Resident #6 on 1/13/25 with diagnoses including Chronic Obstructive Pulmonary Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/16/25 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 8, (continued on next page)

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Community Living Ctr	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicating moderate cognitive impairment. A record review of Orders tab in the electronic medical record, revealed Resident #6 had a Physician's Order, dated 11/25/25 for catheter care. Resident #70 On 12/3/25 at 2:15 PM, during an observation of Percutaneous Endoscopy Gastrostomy (PEG) tube care performed by Licensed Practical Nurse (LPN) #2 for Resident #70, LPN #2 donned a gown and gloves at the entrance and performed hand hygiene before applying gloves. She then opened the clean supply cart multiple times and used the computer mouse while wearing gloves. She entered the room, placed supplies directly on the bedside table without sanitizing the surface or using a barrier, and pressed buttons on the feeding pump while wearing gloves. She removed the PEG dressing while still wearing the same gloves. She cleaned only the PEG tubing, not the insertion site. She removed gloves and reapplied clean gloves without performing hand hygiene. She dried the tubing with gauze, then again removed gloves, performed hand hygiene, and reapplied gloves. She removed a syringe from a storage bag and attempted to flush 150 cubic centimeters (cc) of water; when the water did not move, she used the plunger, met resistance, and exited the room to obtain a stethoscope. She removed her gown, gloves, and supplies upon exit. On 12/3/25 at 2:45 PM, during an observation of LPN #2 returning to Resident #70's room, she applied gloves without performing hand hygiene and not donning a gown before flushing the tube. She gathered supplies and exited the room without performing hand hygiene. On 12/3/25 at 3:28 PM, during an interview with LPN #2, she confirmed she did not sanitize the bedside table or place a barrier before placing supplies. She confirmed she touched the cart, computer mouse, and feeding pump with gloved hands. She stated she should have removed gloves and washed her hands before beginning PEG care and before re-gloving. She confirmed she removed the PEG dressing with contaminated gloves. She reported she did not perform hand hygiene frequently enough and stated the purpose of Enhanced Barrier Precautions was to protect residents from organisms present on staff clothing. On 12/3/25 at 4:10 PM, during an interview with the DON, she stated LPN #2 should have washed her hands before and after care and upon room entry. She stated the PEG site must be cleaned correctly to prevent infection. She stated a barrier should have been used before placing supplies on the bedside table. She stated Enhanced Barrier Precautions were expected during PEG tube care to protect residents from infection. She reported that the manner in which LPN #2 performed care presented a cross-contamination risk. A record review of the admission Record revealed the facility admitted Resident #70 on 2/11/25 with diagnoses including Dysphagia. A record review of the Order Summary Report revealed Resident #70 had a Physician's Order, dated 2/11/25 to clean the Percutaneous Endoscopic Gastrostomy (PEG) site daily with warm soap and water. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/30/25 revealed Resident #70 required a staff assessment for mental status and that her cognitive skills for daily decision making was severely impaired. (continued on next page)

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Community Living Ctr	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Enhanced Barrier Precautions signage posted on Resident #70's door revealed staff were to wear gown and gloves for high-contact care activities, including feeding tube care.