STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345309	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nsg and Rehab Ctr of Halifax Cty	101 Caroline Avenue Weldon, NC 27890

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45789 Based on record review, and resident and staff interviews, the facility failed to conduct care plan meetings for 2 of 3 residents reviewed for care planning (Resident #10, and Resident #24), and failed to update a care plan for Resident 1of 3 residents reviewed for care planning (Resident #24). The findings included: 1. Resident #10 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #10 was cognitively intact. During an interview with Resident #10 on 10/7/2024 at 10:23 A.M. he disclosed he could not remember the last time he participated in a care plan meeting. Calls to the Representative of Person for Resident #10 on 10/8/2024 at 3:47 P.M., and on 10/9/2024 at 8:47 A.M. went unanswered. A review of Resident #10's care plan revealed it had been updated on 6/12/2024 and on 6/19/2024. In an interview with the Social Worker (SW) on 10/8/2024 at 3:35 P.M. she revealed it was her responsibility to schedule care plan meetings, and to send out invites to participants. She stated it was an error on her part not to schedule a care plan meeting for Resident #10. The SW revealed the last care plan meeting for Resident #10 was held on 2/17/2024. During an interview with the Director of Nursing (DON) on 10/8/2024 at 3:40 P.M she revealed care plans were reviewed every 3 months and was not aware Resident #10's last care plan meeting was held on 2/17/2024. She further stated Resident #10's care plan was reviewed on 6/12/2024 and 6/19/2024. In an interview with the Administrator on 10/09/24 at 9:50 A.M. she revealed she was not aware Resident #10 had not had a care plan meeting since 2/17/2024. She further revealed it was the responsibility of SW to schedule the meetings and the responsibility of the DON to ensure the care plan was updated accordingly. 2. Resident #24 was admitted to the facility on [DATE]. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #24's quarterly Minimum Data Set (MDS) dated [DATE] revealed she was cognitively intact and her own responsible party. In an interview with Resident #24 on 10/7/2024 at 10:58 A.M. she revealed she had not participated in any care plan meetings since arrival at the facility on 4/11/2024. Review of Resident #24's care plan initiated on 4/11/2024 revealed the care plan had not been updated. The Social Worker (SW) was interviewed on 10/8/2024 at 3:35 P.M. SW revealed that Resident #24 was supposed to have had a care plan meeting in July 2024. She further stated it was her responsibility to schedule the meeting and it was an error on her part for not scheduling a meeting. An interview with the MDS Nurse on 10/8/2024 at 10:12 A.M. revealed she was responsible for ensuring the care plan was updated. She stated it was an error that Resident #24's care plan had not been updated. The MDS Nurse revealed it was the responsibility of the SW to schedule care plan meetings. During an interview with the Director of Nursing (DON) on 10/8/2024 at 3:40 P.M she revealed the care plan is reviewed every 3 months and was not aware Resident #24's care plan meeting had not been held. She revealed it was the responsibility of the SW to schedule and call for the care plan meetings for residents. During an interview with the Administrator on 10/9/2024 at 9:50 A.M. she revealed it was the responsibility of the Social Worker and the DON to ensure care plan meetings for Resident #24 were held quarterly or as needed.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 20710 Based on lunch meal tray line observation, and staff interviews, the facility failed to maintain the plate warmer, essential equipment to the dietary department, in good operating condition, as evidenced by the plate warmer being inoperable. The findings included: An observation of the lunch meal tray line occurred on 10/09/24 at 11:50 AM. The two cylinder plate warmer was not plugged in or warm to the touch. In an interview on 10/09/24 at 12:04 PM Dietary Staff #1 stated the plate warmer had not worked for over 2 months. In an interview on 10/09/24 at 12:20 PM the Maintenance Assistant revealed he had worked at the facility for 2 months and was not aware the plate warmer was not working or had attempted to repair it. In an interview on 10/09/24 at 1:04 PM the Dietary Manager revealed she had been at the facility for over 2 months and the plate warmer had not worked since she arrived. She revealed the prior maintenance director had been unable to repair the plate warmer and she told the Administrator it was not working. In an interview on 10/09/24 at 12:17 PM the Administrator revealed that the prior Maintenance Director had been unable to repair the plate warmer. She indicated the dietary staff utilized insulated plates and staff served food immediately after it reached the halls.