

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345367	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Liberty Hc Svcs of Golden Years Nsg Ctr, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7348 North West Street Falcon, NC 28342	

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 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48007</p> <p>Based on staff interviews and record reviews the facility failed to apply for an updated level I Preadmission Screening and Resident Review (PASRR) for a resident admitted with mental health diagnoses for 1 of 3 residents reviewed for PASRR (Resident #36).</p> <p>The findings included:</p> <p>A review of the medical record for Resident #36 was admitted into the facility on [DATE] with diagnoses that included major depression and psychotic disorder.</p> <p>A review of Resident #36's most recent PASRR Level I screen was dated 11/16/21 and marked no to the question is there a Mental Health diagnosis.</p> <p>The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #36 was cognitively intact and was taking antipsychotic medication.</p> <p>An interview with the Administrator on 8/29/24 at 9:26 AM revealed there was not a Social Worker in the building since the last Social Worker resigned. He stated that the Social Worker duties were supposed to be split between the administrative staff which included reviewing the PASRR. He further stated that Resident #36 should have been screened for a PASRR when admitted into the facility.</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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