

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675540	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/20/2025
NAME OF PROVIDER OR SUPPLIER  Liberty Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1206 N Travis St Liberty, TX 77575	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 2 of 17 residents reviewed for care plans. (Residents #4 &amp; #54) 1. The facility did not have a care plan to address Resident #4's hospice care. 2. The facility did not have a care plan to address Resident #54's indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine) or catheter care. These failures could place residents at risk of not having their individual needs met and not receiving needed services. Findings included: 1. Record review of the face sheet dated 08/20/25 indicated Resident #4 was a [AGE] year-old male admitted on [DATE]. His diagnoses included cerebral palsy (a congenital disorder of movement, muscle tone, or postured due to abnormal brain development often before birth) and muscle wasting and atrophy (waste away, especially because of degeneration of cells). Record review of a significant change MDS dated [DATE] indicated Resident #4 had severely impaired cognition, was dependent for all ADLs, and was receiving hospice care. Record review of the care plan last updated 07/15/25 did not indicate that Resident #4 was under the care of hospice. Record review of a physician order dated 07/21/25 indicated Resident #4 was admitted to hospice services. During an observation and interview on 08/18/25 at 9:27 a.m., Resident #4 was in bed with his family member at bedside. Resident #4 was not responding to verbal or touch stimuli from his family member. The family member said the facility had called him that morning because of Resident #4's change of condition and hospice had determined he was actively dying. During an interview on 08/20/25 at 1:11 p.m., the DON said that while the facility was without an MDS Nurse that she and the ADON were responsible for writing new care plans. She said they learn of new or changed treatments and orders in the morning meeting by reviewing the 24-hour report, new orders, and incident reports. She said she reviewed Resident #4's care plan and there was no care plan for hospice care. She said it was just overlooked. She said the possible negative outcome of not having a care plan for hospice services could be the resident not receiving the appropriate care. During an interview on 08/20/25 at 1:35 p.m., the Administrator said the former MDS Nurse last day was 07/21/25. She said the DON and ADON were responsible for creating care plans until another MDS Nurse could be trained. She said she and the DON searched Resident #4's care plan for a hospice care plan and one had not been created. She said the care plan was just missed. She said there was no negative outcome for Resident #4 not having a hospice care plan because he had hospice serves in place, the order for the service, and had received the ordered care. 2. Record review of a face sheet dated 08/20/25 indicated Resident #54 was an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnosis included chronic diastolic (congestive) heart failure (a chronic condition in which the heart does not pump blood as well as it should) and type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) with hyperglycemia (high blood sugar). Record review of a significant change MDS dated [DATE] indicated Resident #54 had a BIMS score of 11 indicating she had moderate cognitive impairment, was dependent for most ADLs, and was incontinent of urine and bowel. Record review of a care plan last dated 07/08/25 indicated Resident #54 had no care plan to address her indwelling urinary catheter. Record review of a physician order dated 07/30/25 indicated Resident #54 was to have an indwelling urinary catheter in place related to urinary retention. During an observation and interview on 08/19/25 at 8:35 a.m., Resident #54 was lying in bed in her room with her catheter bag hanging on the bed below bladder level. She said she had the catheter because she was having trouble urinating without it. During an interview on 08/20/25 1:11 a. m., the DON said she had reviewed Resident #54's care plans and that there was no care plan for her catheter or catheter care. She said the possible negative outcome for not having a care plan for the catheter and care could be the resident not receiving the appropriate care. During an interview on 08/20/25 1:35 p.m., the Administrator said she expected resident care plans were to be complete and address all needs, goals, and interventions for each resident. She said there was no negative outcome for Resident #54 not having a catheter care plan because the resident had the catheter and receiving the care required to maintain the catheter. Record review of the facility's undated Comprehensive Care Plans policy indicated It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's</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>(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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 6 residents (Resident #25) reviewed for respiratory therapy. The facility failed to keep the oxygen concentrator filter clean for Resident #25. This failure could place residents at risk of receiving incorrect or inadequate oxygen support which could result in a decline in health. Findings included: Record review of Resident #25's face sheet dated 08/18/25, indicated he was a [AGE] year-old male readmitted on [DATE] with diagnoses of chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), respiratory failure (a condition where the lungs are unable to adequately exchange oxygen and carbon dioxide resulting in dangerously low oxygen levels in the blood) and heart failure (condition in which the heart does not pump blood as well as it should). Record review of Resident #25's most recent quarterly MDS assessment dated [DATE] indicated he had a BIMS score of 12 which indicated moderately impaired cognition. The assessment indicated medical diagnoses of respiratory failure, chronic obstructive pulmonary disease and heart failure and received oxygen therapy on during the last 14 days while a resident in the facility. Record review of Resident #25's care plan with a target date of 10/10/25 indicated he received oxygen therapy related to shortness of breath with interventions including oxygen setting at 2-4 liters per minute per nasal canula (a think flexible tube that delivers supplemental oxygen through your nose) per physician order. Record review of Resident #25's Physicians Order Summary dated 08/18/25 indicated he was prescribed oxygen at 2-4 liters per minute humidified oxygen by nasal canula continuously with an order date of 04/11/25. During an observation and interview on 08/18/25 at 08:55 a.m., Resident #25 was lying in bed with oxygen per nasal canula set at 4 liters/minute to an oxygen concentrator with two black filters. The oxygen concentrator filters were covered with a light gray powdery substance. Resident #25 said he wore his oxygen all the time and the facility changed his oxygen tubing and cleaned the filters sometimes, but he was not sure when the last time they were cleaned. During an observation and interview on 08/20/25 at 8:00 a.m., Resident #25 was lying in bed with oxygen per nasal canula set at 4 liters/minute to an oxygen concentrator with two black filters. The oxygen concentrator filters were covered with a light gray powdery substance. Resident #25 said he wore his oxygen all the time and the facility changed his tubing and cleaned the filters sometimes, but he was not sure when the last time they were cleaned. During an interview on 08/20/25 at 8:32 a.m., RN A said she was providing care for Resident #25 on 08/20/25 and 08/19/25. She said Resident #25's oxygen concentrator filters were dirty and should have been changed or cleaned. RN A said she was responsible for ensuring the oxygen concentrator filters were clean and the ADON was the back up to double check. She said she was educated on ensuring oxygen concentrator filters were cleaned but she overlooked them. RN A said the resident risk of dirty oxygen concentrator filters was possible contamination. During an interview on 08/20/25 at 8:35 a.m., the DON said the Maintenance Director was responsible for ensuring oxygen concentrator filters were cleaned and the ADON was the back up to double check. She said the charge nurses inspected oxygen concentrators daily to ensure the oxygen concentrator filters were clean, the oxygen tubing and the humidifier bottles (oxygen can be drying to your nose so some patients use a humidifier bottle to moisten the oxygen you breath) were changed weekly and dated. The DON said the Maintenance Director, ADON and charge nurses were educated on cleaning filters on oxygen concentrators. She said Resident #25's oxygen concentrator filters were overlooked. She said the resident risk of soiled oxygen concentrator filters was potentially the oxygen concentrator may not be as effective as it should be. The DON said her expectation was charge nurses inspect the oxygen concentrators daily to ensure the filters were clean and tubing changed weekly and dated, the Maintenance director clean the filters as needed and ADON ensure the concentrator filters were cleaned as needed. During an interview on 08/20/25 at 8:40 a.m., the Administrator said the Maintenance Director was responsible for ensuring oxygen concentrator filters were cleaned and the ADON was the back up to double check. She said the charge nurses inspected the oxygen concentrators daily to ensure concentrator filters were clean. She said the Maintenance director, ADON and charge nurses were educated on cleaning filters on oxygen concentrators. She said Resident #25's oxygen concentrator filers were overlooked. She said the resident risk of soiled oxygen concentrator filters was potentially the oxygen concentrator may not be as effective as it should be. She said her</p>		