STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345367	A. BUILDING ______ B. WING ______	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY HC SVCS OF GOLDEN YEARS NSG CTR, LLC	**7348 NORTH WEST STREET FALCON, NC 28342**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 08/27/2024 through 08/29/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #HIXM11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/27/2024 through 08/29/2024. Event ID# HIXM11. The following intakes were investigated NC00216002 and NC00218392. 7 of the 7 complaint allegations did not result in deficiency.	F 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires	F 645		9/20/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/20/2024

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.

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F 645	Continued From page 1 specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section-	F 645		

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F 645	Continued From page 2 (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: 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). The findings included: A review of the medical record for Resident #36 was admitted into the facility on 4/5/24 with diagnoses that included major depression and psychotic disorder. 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. The admission Minimum Data Set (MDS) dated 4/15/24 revealed Resident #36 was cognitively intact and was taking antipsychotic medication. 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	F 645	1. Corrective action for residents) affected by the alleged deficient practice: On 8/29/2024, the Administrator submitted through NCMUST. a Preadmission Screening and Resident Review (PASRR) for resident # 36. It was submitted on 8/29/2024 and Pending Acceptance 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility have the potential to be affected. On 9/20/2024, the Administrator completed 100 % audit of all residents who has had an expired PASRR, in order to validate that the State Mental Health Authority was notified and a new resident review request was sent through the NCMUST system for any resident who require a new PASSR 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 9/9/2024, the Administrator completed education with the facility Social Worker/Admission Coordinator and Health Information Manager which included the	

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F 645	Continued From page 3 PASRR. He further stated that Resident #36 should have been screened for a PASRR when admitted into the facility.	F 645	PARR assessment process and requirements for when a level II PASARR is to be completed. The Health Information Manager will notify the Social Worker when a new diagnosis has been added that would potentially qualify for a level II PASARR. The Administrator also, on 09/05/2024 educated the Social Workers of the responsibility of requesting Level II PASRR reviews when indicated. Any Social Worker, Health Information Manager or Admissions Coordinator who did not receive in-service training by 09/13/2024 will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all newly hired Social Workers, Admission Personnel and Health Information Managers and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Social Worker or designee will monitor compliance utilizing the F645 Quality Assurance Tool weekly x 4 weeks then monthly x 2 months. The Social Worker or designee will monitor for compliance with audit of new resident records for the need of a Level I| PASARR screening. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is	

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F 645	Continued From page 4	F 645	initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager.	