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 _____	C 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

(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 from 10/7/2024 through 10/9/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID#QP6011.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/07/2024 through 10/09/2024. Event ID#QP6011. The following intake was investigated: NC00220535. 2 of 2 allegations did not result in a deficiency.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		10/29/24

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

Electronically Signed | 10/25/2024

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 _____	C 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

(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
F 656	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: 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 6/13/2023.	F 656	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	

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 _____	C 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

(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
F 656	Continued From page 2 The quarterly Minimum Data Set (MDS) dated 7/12/2024 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	F 656	F656 1. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The care plans should be reviewed, updated and revised as a resident's condition changes and a care plan meeting held by the IDT with the resident and or responsible party. The care plan meeting for the identified resident #24 to provide safe effective care was held and updated on 10/16/2024. Care plan meeting for the identified resident # 10 to provide safe effective care was scheduled for 10/16/2024. Family of resident #10 rescheduled care plan meeting for 11/5/2024. 2. CORRECTIVE ACTION FOR RESIDENTS WITH THE POTENTIAL TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: All residents have the potential to be affected by the alleged deficient practice 100% care plan audit was completed on 10/11/2024. Three residents were found to need an updated care plan and care plan meeting. On 10/11/2024 care plan meetings were scheduled for the 3 residents found on audit. 3. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:	

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 _____	C 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

(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
F 656	Continued From page 3 and the responsibility of the DON to ensure the care plan was updated accordingly. 2. Resident #24 was admitted to the facility on 4/9/2024. Resident #24's quarterly Minimum Data Set (MDS) dated 7/23/2024 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	F 656	The Interdisciplinary Team members were in-serviced by the administrator on 10/10/2024 with focus on: purpose of care plan, when care plans should be initiated and updated, and when care plan meetings should be held. 4. MONITORING OF CORRECTIVE ACTIONS: The Director of Nursing or designee will audit up to 5 current residents in order to validate whether or not the care plans have been developed and revised that coincide closely with the assessment reference date. This will be done on weekly basis x 4 weeks then monthly x 2 months. Reports will be presented to the monthly Quality Assurance Performance Improvement meeting by the Director of Nursing or designee to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	

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 _____	C 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

(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
F 656	Continued From page 4 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.	F 656		
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: 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	F 908	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F908 1. For dietary services, a corrective action was obtained on 10/09/2024. During tray line observation on 10/09/2024, it was noted dietary services did not plug in plate warmer stating it was not in operating condition. Plate warmer	10/29/24

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 _____	C 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

(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
F 908	Continued From page 5 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.	F 908	repaired by maintenance on 10/10/2024. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 10/10/2024 Maintenance completed walk through of kitchen with dietary manager and administrator to review and address any further maintenance needs; No new issues were identified. 3. Systemic changes In-service education was provided to all full time, part time, and as needed dietary and environmental staff on 10/24/2024 by Administrator. Topics included: " Procedures for contacting and completing facility work order forms for inoperable equipment. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Maintenance will maintain and address work orders for dietary inoperable equipment using the facility work order forms.	

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 _____	C 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

(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
F 908	Continued From page 6	F 908	4. Quality Assurance monitoring procedure. The maintenance director or assignee will monitor maintenance needs in the kitchen weekly x 4 weeks then monthly x 3 months using TELS and Quality Assurance (QA) Audit Tool. Reports will be presented to the monthly Quality Assurance Performance Improvement committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly Quality Assurance Performance Improvement Meeting.	