DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-							
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING			R-C 05/16/2024		
NAME OF PROVIDER OR SUPPLIER					03/10/2024		
LIBERTY COMMONS NSG & REHAB CTR OF JOHNSTON CTY			BENSON, NC 27504				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	IX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
INITIAL COMMENTS		F	000				
PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	RE		TITLE		(X6) DATE	
	DICARE & I	DICARE & MEDICAID SERVICES IES (X1) PROVIDER/SUPPLIER/CLIA JUPPLIER 345519 SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION) OMMENTS OMMENTS w-up survey has been completed and 'is back in compliance effective	DICARE & MEDICAID SERVICES IES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 345519 B. WING SUPPLIER B. WING NSG & REHAB CTR OF JOHNSTON CTY ID SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION) ID OMMENTS F w-up survey has been completed and ID	DICARE & MEDICAID SERVICES IES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE JBUPDIER 345519 B. WING SUPPLIER S1 NSG & REHAB CTR OF JOHNSTON CTY S1 SUMMARY STATEMENT OF DEFICIENCIES ID CH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG TAG OMMENTS F 000 w-up survey has been completed and F 000 vis back in compliance effective ID IS back in compliance effective ID	DICARE & MEDICAID SERVICES IES (X1) PROVIDERSUPLIERCIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 345519 Image: Construction of the cons	<pre>IEALTH AND HUMAN SERVICES OWN DICARE & MEDICAND SERVICES OWN IES (x) PROVIDENSIPPLIERCIA 1DENTIFICATION NUMBER: (x) JULTIFIC CONSTRUCTION (x) 1DENTIFICATION NUMBER: 1DENTIFICATION NUMBER: (x) 1DENTIFICATION NUMBER: 1DENTIFICATION NUMBER: (x) 1DENTIFICATION NUMBER: 1DENTIFICATION NUMBER:</pre>	

Electronically Signed

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.

PRINTED: 05/16/2024