STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345503	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nsg and Rehab Ctr of Rowan County	**4412 South Main Street , Salisbury, North Carolina, 28147**

(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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 9/22/2025 through 9/25/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D43C-H1. In accordance with QSO-26-01-All, the posting of this Statement of Deficiencies was delayed as a result of the Federal Government shutdown. The exit date of this survey has been adjusted based on CMS guidance.	E0000		11/19/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 9/22/2025 through 9/25/2025. Event ID# 1D43C-H1. The following intake was investigated 748309. 1 of the 2 complaint allegations resulted in deficiency. In accordance with QSO-26-01-All, the posting of this Statement of Deficiencies was delayed as a result of the Federal Government shutdown. The exit date of this survey has been adjusted based on CMS guidance.	F0000		11/19/2025
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, observations, staff and resident interviews, the facility failed to provide access to the call bell, telephone, and water cup to accommodate a visually impaired resident. This resulted in Resident #6 yelling for assistance or asking his roommate to turn on the call bell, missing phone calls, and prevented access to the water cup as he wanted.	F0558	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. F558 Corrective Action for Resident Affected On 9/24/2025, immediately upon discovery, Resident #6's	11/20/2025

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 reverse for further 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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F0558 SS = D	Continued from page 1 This was for 1 of 1 resident reviewed for accommodation of needs (Resident #6). The findings included: Resident #6 was readmitted on 4/15/2025 with diagnoses including heart failure, kidney disease, gastro-esophageal reflux disease, dysphagia (trouble swallowing), Barrett's esophagus (inflammation of the esophagus), macular degeneration, legal blindness, and history of falling. The most recent quarterly Minimum Data Set Assessment (MDS) dated 8/22/2025, indicated Resident #6 was cognitively intact. He was dependent with mobility, used a wheelchair, needed extensive assistance with toileting and transferring, and required supervision with set up with eating. Coding for vision showed highly impaired-object identification in question, but eyes appear to follow objects. The Care Plan revised on 10/5/2023 for Resident #6, showed the focus area of impaired vision related to macular degeneration and legal blindness. The goal was no decline of visual function with target date of 11/14/2025. Interventions included - to advise Resident #6 where personal items were placed, and to be consistent with the location of the items. Further interventions were to keep the call bell within reach and encourage the resident to call for assistance with transfers. The Care Plan revised on 6/02/2025 for Resident #6, showed the focus area of increased risk for falls related to a history of falls and gait/balance problems. The goal was to minimize the risk for falls and be free of injury using current interventions. Interventions included - to anticipate and meet Resident #6's needs as much as possible and keep frequently used objects within resident's reach as much as possible. An observation and interview with Resident #6 on 09/22/2025 at 12:40 PM revealed resident sitting up in his wheelchair with his lunch tray on the overbed table in front of him. The call bell was observed laying across the seat of the recliner chair behind him. When asked if he had trouble reaching his call bell, Resident #6 turned in his wheelchair and reached his arm toward the recliner behind him but couldn't locate	F0558	Continued from page 1 call bell, telephone, and water cup were repositioned to ensure accessibility whether he is sitting in his wheelchair or in his bed. The Director of Nursing (DON) and nursing staff engaged the resident and ensured his preferences are taken into consideration and met. Corrective action for residents with the potential to be affected by the alleged deficient practice. The facility recognizes that all residents have the potential to be affected by this deficient practice. On 9/24/2025 the Director of Nursing, Assistant Director of Nursing and Nursing Supervisor completed an audit of all other residents ensuring that their needs and preferences for accommodations are being met, including accessibility to essential items such as call bells, telephones, and water. Systemic Changes to Prevent Recurrence: On 9/25/2025 the Director of Nursing, Assistant Director of Nursing and Nursing Supervisor began in-service education to all full time, part time, and as needed staff. Topics included: nursing and caregiving staff were re-educated about the importance of ensuring that residents have access to call bells, telephones, and drinking water at all times. es. Any of above identified staff who does not complete the education by 9/28/2025 will not be allowed to work until education is completed. 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. Quality Assurance monitoring procedure. Beginning the week of 9/28/2025, the Director of Nursing/designee will conduct audits of 5 resident rooms to ensure corrective actions are maintained. This will be completed weekly x 4 weeks then monthly x 2 months. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Reports will be presented to the weekly Quality Assurance committee by the Administrator	

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F0558 SS = D	Continued from page 2 or reach the bell. The resident then said, “Here lately it seems to get away from me a lot. I holler for them if I can't find it.” During an observation and interview on 09/22/2025 at 3:17 PM, Resident #6 was sitting up in his wheelchair, the call bell was lying in the recliner behind resident, out of reach. During this observation the resident's phone rang along with an electronic voice announcing he had a call. He was unable to reach the phone that was ringing which was on the charger on top of his dresser. Observation further revealed a second cordless phone on Resident #6’s bedside table which he also had been unable to reach and a third cordless phone sitting on his roommate’s bed. His roommate, Resident #41, assessed on 07/14/2025 with intact cognition, was asked about why Resident #6’s phone was on his bed. Resident #41 stated he had the phone on his bed to answer it for Resident #6’s when he couldn’t get to it. An observation on 09/23/2025 at 8:22 AM, showed Resident #6 sitting in his wheelchair with the overbed table in front of him. The call bell was lying across his bed out of his reach. On 09/23/2025 at 12:54 PM an observation of Resident #6 showed him sitting up in his wheelchair for lunch. The call bell was observed to be lying across the recliner behind him, out of his reach. During an observation and interview on 09/24/2025 at 8:30 AM, Resident #6 was observed sitting in the wheelchair. His call bell was not within reach. It was observed lying in recliner behind him. When asked where the call bell was, he patted around on his table and reached over to the bed with his hands but couldn't locate it. Asked what he would do if he needed help, he stated, “He would ring,” while pointing to his roommate, Resident #41. When asked what he would do if his roommate wasn't there, Resident #6 replied that he would holler. During an interview on 09/24/2025 at 8:40 AM, Resident #6’s roommate, who was Resident #41, stated that he had pushed the call bell and answered the phone for Resident #6 when he wasn’t able to get to them, maybe several days of a week.	F0558	Continued from page 2 to ensure corrective action initiated as appropriate. Completion Date: 11/20/2025.	

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F0558 SS = D	Continued from page 3 On 09/24/2025 at 11:54 AM, Resident #6 was observed sitting up in wheelchair in front of his recliner, in the room by himself. His call bell was lying on recliner chair arm behind Resident #6. During the observation one of the residents' three cordless telephones rang. All three cordless phones were out of his reach and Resident #6 was unable to get to the telephone to answer it. An observation of the cordless phone screen showed 34 missed calls. When asked about how often he could not reach his phone, he said he often had trouble answering the phone and thought it probably had fallen on the floor. Further observation revealed Resident #6 was unable to reach his water cup which was on the bedside table in the space between the foot of the bed and bathroom door out of his reach. He had bumped into the table when propelling around the room and was unable to turn the wheelchair around to reach the call bell or water. During an interview with Nurse #2 on 09/24/2025 at 11:58 AM, she confirmed she was Resident #6's assigned nurse that day shift. Nurse #2 stated Resident #6 could propel himself in the wheelchair to move about his room. She further stated he didn't move around much because he was blind, so he preferred staff to move him, so he didn't bump into things. During an interview in Resident #6's room on 09/24/2025 at 12:29 PM, Nurse Aide (NA) #6 confirmed she was assigned to Resident #6 that day during day shift. When asked about the resident's call bell, she looked at the call bell in the recliner chair and indicated that's where she put it there when he's up in his wheelchair. When asked about him reaching the call bell, she said she had seen him move around in the wheelchair in his room. An observation and interview on 09/24/2025 at 3:51 PM revealed Resident #6 was sitting in his wheelchair in his room by himself. The call bell was on the recliner chair arm behind him. The overbed table with water cup was in the space between the foot of the bed and bathroom door. Resident #6 was observed reaching out with his hands to his left toward the bed but couldn't reach his water on the table and said he wanted to be able to get his water. Further observation revealed that two cordless phones were out of Resident #6's reach. One was on the dresser, and the other was lying on his roommate's bed. When asked if he wanted to be able to use the phone himself, Resident #6 indicated he	F0558		

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F0558 SS = D	Continued from page 4 wished he could reach the phone so he could answer it himself. An interview and observation were done on 09/25/2025 at 3:57 PM with NA #4 who was currently assigned to Resident #6 and cared for him often. Resident #6 was not in the room at the time of the observation. The call bell was observed to be tucked into the pocket of the recliner chair. When asked how Resident #6 used the call bell, she stated that when he was in the recliner or bed as he usually was on her evening shift, she put call bell in the pocket on the side of his recliner. She stated he sometimes had his roommate turn his call light on for him when he can't use his call bell. She further explained that when the overbed table was in front of him in the wheelchair, he had bumped into the table trying to propel himself and didn't wheel around if the table was in front of him. The interview further revealed when she brought him his tray, she would make sure to put his hand to the food bowl, hand him his spoon, open his cartons, and make sure he got going with feeding himself before leaving his room. An interview was done on 09/25/2025 at 4:04 PM with Nurse #3, who was currently assigned to Resident #6. She indicated Resident #6 had been able to push the overbed table, but because of his blindness he was not able to move around the table without bumping into the bed, preventing him from propelling around room to reach items. She further said he answered the phone, and he had made calls out. When asked about how she knew how to care for visually impaired residents, she said that during facility orientation she was instructed to look at the care plan to know how to provide specific care for residents with visual impairments. An interview was conducted with the Director of Nursing (DON) with the Nurse Consultant present on 09/25/2025 at 4:21 PM. The DON explained that any resident specific needs related to blindness or low vision would be in the resident's care plan. The DON further explained when she went into Resident #6's room she made sure his water and call bell were in reach and expected all staff to make sure the resident could reach his call bell, phone, and water.	F0558		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F0584	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	11/20/2025

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F0584 SS = D	Continued from page 5 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interviews, the facility failed to provide a clean homelike environment when they failed to maintain a sink drain that leaked in 1	F0584	Continued from page 5 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. F584 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. For environmental services, a corrective action was obtained on 9/24/25. Based on observation, record review, and interviews, the facility failed to provide a safe, clean, comfortable, home-like environment. On 9/24/25 the maintenance assistant repaired the leaking sink in resident #50's room. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 9/29/2025 the environmental services manager began auditing all resident bathrooms to ensure they were free of leaks or plumbing issues that could compromise a homelike environment. This audit was completed on 10/03/2025. The Maintenance assistant repaired any sinks that were found to have leaks. All repairs were completed by 10/10/2025. Systemic Changes The Environmental Services Manager began educating all full-time, part-time, and as needed	

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F0584 SS = D	Continued from page 6 of 4 shared bathrooms used only by Resident #50. The findings included: An observation on 9/22/25 at 1:55 PM of the bathroom in Resident #50's room revealed an approximate twelve-inch diameter puddle of clear liquid substance that resembled water on the bathroom floor. The liquid substance was located under and in front of the bathroom sink. The sink was a wall mounted unit and had two water feed lines from the wall to the bottom of the sink. The lines did not have leak protection covers. The sink had a center drain extending down to the p-trap (a plumbing device that prevents sewer gases from entering the facility by maintaining a water seal. P-traps are commonly found under sinks, bathtubs and showers), then a pipe from the p-trap that terminated at the wall of the bathroom. The bathroom floor was a solid surface linoleum type floor mostly beige/tan in color with blue/green accents. An observation on 9/23/25 at 10:24 AM of the bathroom in Resident #50's room revealed an approximate twenty-four-inch diameter puddle of clear liquid substance that resembled water on the floor of the bathroom between the sink and the toilet. There were no wet floor signs displayed in the bathroom. An observation on 9/24/25 at 11:54 AM of the bathroom in Resident #50's room revealed a puddle of clear liquid substance that resembled water on the floor of the bathroom. A clear liquid was observed dripping from the sinks p-trap drain, about one drip every two to three seconds, creating a puddle under the sink. The puddle was about two feet in diameter extending out from under the sink. There were no wet floor signs displayed in the bathroom. An interview was conducted with the Director of Maintenance on 9/24/25 at 12:07 PM. He observed the puddle of liquid on the floor in Resident #50's bathroom and stated the puddle on the floor was water that leaked from the p-trap of the bathroom sink. He confirmed the p-trap had a crack possibly from the fitting being overtightened, which caused water to leak out of the p-trap onto the bathroom floor. The Maintenance Director stated he was not aware of the leak until this observation. He stated the facility used a work order system to inform maintenance about repair issues. He continued that the process was for staff, which included housekeeping staff, nurse aides	F0584	Continued from page 6 staff. Topics included: How to promptly report maintenance issues How to promptly document maintenance issues through work orders 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. Quality Assurance monitoring procedure. The Maintenance Director will conduct weekly environmental rounds in resident areas for 4 weeks, then bi-weekly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored, and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Environmental Service Manager. Completion Date: 11/20/2025	

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F0584 SS = D	Continued from page 7 and nurses, to fill out a work order that was located at the nurse's station and place it in the box attached to the maintenance office door. The facility Maintenance Worker would check the work order box every morning, prioritize issues, then complete the repairs. He also stated if repairs needed immediate attention from maintenance that staff could verbally inform the Maintenance Worker. An interview conducted on 9/24/25 at 12:27 PM with the facility Maintenance Worker revealed he had not been informed of any issues in Resident #50's room until 9/24/25 when he was informed by the Director of Maintenance. An interview conducted with Housekeeper #1 on 9/24/25 at 12:24 PM revealed Housekeeper #1 cleaned Resident # 50's room and the bathroom on 9/23/25. She stated she did not notice water on the bathroom floor or a leaking pipe in the bathroom when she cleaned. She also stated had she noticed water on the floor or a leaking pipe she would have informed the Maintenance Worker or her supervisor. An interview conducted on 9/24/25 at 2:51 PM with Nurse Aide (NA #3) revealed NA #3 provided care for Resident #50 on 9/24/25, which included taking Resident #50 to the bathroom around 8:15 AM. She stated she did not notice water on the bathroom floor or a leaking pipe in the bathroom when she provided care for Resident #50. She also stated, due to Resident #50's impaired cognition, Resident #50 would use the bathroom on her own. NA #3 stated she did not go back into the room until around 1:00 PM at which point maintenance had fixed the leaking drain. She stated if she had seen the water on the floor she would have cleaned up the water then notified the Maintenance Worker verbally or filled out a work order. An interview conducted on 9/24/25 at 3:39 PM with Nurse #3 revealed she worked with Resident #50 around lunch time on 9/24/25. She did not notice any water on the floor in the bathroom. Nurse #3 stated if she had noticed water on the floor she would have informed the Maintenance Worker or the Director of Maintenance. An interview was conducted with the Nursing Home Administrator (NHA) on 9/25/25 at 10:38 AM. The NHA stated the severity of a water leak would determine the	F0584		

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F0584 SS = D	Continued from page 8 staff response and first staff should make the area safe for residents. Then place wet floor signs in the area and notify maintenance with a work order or, if immediate attention was needed, verbally so maintenance can address the issue right away.	F0584		
F0805 SS = D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide a pureed diet (a smooth, creamy consistency/ texture) to a resident on an ordered therapeutic diet. Resident #24 was observed eating a moist to minced (food that can be easily mashed with little pressure from metal dinner fork, not sticky, no larger than 4 millimeters) breakfast meal. This deficient practice affected 1 of 8 residents reviewed for food form (Resident #24). The findings included: Resident #24 was admitted to the facility on 8/4/2023 with diagnoses which included dysphagia (difficulty swallowing), vascular dementia, and decreased appetite. Resident #24 had a physician's order dated 2/15/2024 for a regular diet, pureed texture, thick liquids consistency. Resident #24's Care Plan, last revised on 3/20/2025, indicated the following interventions: 1) observe for/document/report to MD as needed (PRN) for signs and symptoms of dysphagia, pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned at meals, 2) provide, serve diet as ordered; and 3) Registered Dietician (RD) to evaluate and make diet change recommendations PRN.	F0805	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. F805 For dietary services, a corrective action was obtained on 9/23/2025 and 9/25/2025. Based on observation, record review, and interviews the facility failed to provide the diet texture as prescribed to 1 of 1 residents reviewed. On 09/24/2025 Resident #24 was assessed by the facility nurse practitioner to ensure there were no adverse effects from receiving food that was not pureed. No adverse effects were found. On 9/23/2025 Dietary staff was educated by Regional Dietary Manager on preparing pureed breakfast food for resident #24. Orders, meal ticket, and care plan reviewed 9/24/2025 to ensure reflection of current diet recommendations. On 9/24/2025 IDT reviewed Resident #24 for weight loss and risk concerns. 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 10/6/2025 Therapy Consultant and Senior Nutrition Service Coordinator provided hands on texture training in the facility kitchen. All textures demonstrated by dietary staff as well as diet exception spreadsheet review. On 10/7/2025 Dietary Manager attended company-wide Dietary Manager meeting with focus on diet textures training competency. On 10/10/2025 all orders, meal tickets, and	11/20/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nsg and Rehab Ctr of Rowan County	**4412 South Main Street , Salisbury, North Carolina, 28147**

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F0805 SS = D	Continued from page 9 Resident #24's quarterly Minimum Data Set (MDS) dated 8/15/2025, revealed she was severely cognitively impaired. She had range of motion impairment in her upper extremities and required setup and supervision assistance when eating. The MDS indicated Resident #24 had a swallowing disorder and was on a therapeutic mechanically altered diet. The MDS further revealed Resident #24 demonstrated coughing or choking during meals or when swallowing medications. An observation of Resident #24 was conducted on 9/23/2025 at 8:41 AM. She was observed lying in her bed sitting upright with breakfast in front of her on her overbed table. Consumption of her breakfast meal revealed 75% consumed. The breakfast plate revealed a serving of square piece of formed eggs with a baked cheese topping, a small bowl of regular consistency oatmeal with visible oats, and pureed toast. The meal ticket for Resident #24 revealed pureed diet, thick fluids-mildly thick. An interview and observation conducted with Nurse #1 on 9/23/2025 at 9:04 AM revealed that she delivered and assisted Resident #24 with her breakfast meal. She identified Resident #24 as consuming a pureed meal for breakfast. She further stated that the eggs identified on the plate always looked like this, and the oatmeal always looked regular with visible oats. She further stated sometimes the consistency of the meals will appear different depending on who was working in the kitchen. Nurse #1 stated the breakfast meal was appropriate for Resident #24. During an interview with the Dietary Cook #1 on 9/23/2025 at 9:15 AM, she stated she did not puree the eggs because it would make them too “runny.” She further revealed the oatmeal was never pureed. She stated the eggs may have seemed hard because they sat on top of the steam table for a long time. She stated she provided a cheese bake on top of the eggs for the pureed meal so they would have more flavor. Dietary Cook #1 stated pureed consistency was very thick and smooth. The Dietary Cook #1 revealed she did not follow the recipe for pureed breakfast meals, and she did not state a reason for not following the recipes. Dietary Cook #1 further stated cream of wheat, oatmeal, and grits were already pureed and come in a pureed form. An interview was conducted with Dietary Cook #2 on 9/25/2025 at 9:23 AM. Dietary Cook #2 was able to	F0805	Continued from page 9 care plans were updated to reflect current diet orders. Systemic changes In-service education was provided to all full time, part time, and as needed staff on 10/1/2025 by Corporate Dietician, Regional Director of Operations and Regional Dietary Services Manager. Topics included: Purpose and importance of providing correct diet. Production process to ensure all textures made correctly for tray line. Tray line process to call out diets. 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. Quality Assurance monitoring procedure. The Dietary Service Director and Nursing staff will monitor procedures for providing diet orders weekly x 4 weeks then monthly x 2 months using the QA Audit which will include reviewing meal trays at each meal to ensure diet orders provided as ordered. Audits began on October 20, 2025. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Completion Date: 11/20/2025	

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F0805 SS = D	Continued from page 10 explain the difference in altered diets when preparing meals for the residents. Dietary Cook #2 stated there was a difference between the different types of textures of the foods, explaining moist to minced chopped food was ground-up food that had a bumpy texture while pureed food looked smooth, like baby food. He stated he was unaware Resident #24 had received a moist to minced breakfast on the morning of 9/23/2025. Dietary Cook #2 worked as a diet aide on the morning of 9/23/2025. Dietary Cook #2 stated a resident who received the wrong texture diet could choke or aspirate. The recipe instructions for pureeing the eggs and oatmeal specified placing the ingredients in a food processor until a smooth consistency was achieved, with liquid added as needed. An interview and observation were conducted with the Dietary Manager on 9/23/2025 at 9:30 AM. The Dietary Manager observed the breakfast plate and stated the food items were pureed. She stated the oatmeal was not normally pureed and further revealed the breakfast tray was right in its consistency. The Dietary Manager verified Resident #24 was to receive a pureed therapeutic diet order for meals. The Dietary Manager stated a resident diet order was entered into their computer system and tray tickets that contain the order were printed out for each meal. She explained at mealtimes one staff member would call out the diet order from the ticket and the cook would plate the correct diet and consistency of foods items. The Dietary Manager verified the dietary department had recipes for hot cereal puree and egg and sausage strata puree. The Dietary Manager verbalized the recipe was not followed on 9/23/2025 by Dietary Cook #1. An interview and observation were conducted with the Director of Nursing (DON) on 9/23/2025 at 11:29 AM of Resident #24's breakfast meal. The DON stated a puree meal should be creamy, separated, and with no lumps. She further stated the oatmeal was already mushy. She did verify the eggs were not of puree consistency. The DON verbalized the dietary department should deliver the correct meal to the residents and the nurse aides were to verify the correct meal was being delivered to the residents. The DON stated if there were discrepancies with any meals she should be notified. The DON stated she was not notified of Resident #24 receiving the incorrect therapeutic meal at breakfast on 9/23/2025.	F0805		

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F0805 SS = D	Continued from page 11 An interview was conducted with the Administrator on 9/25/2025 at 1:05 PM. The Administrator stated that residents must receive the physician-prescribed diet and consistency.	F0805		
F0810 SS = D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, resident and staff interviews, and observations, the facility failed to provide resident meals in bowls along with preferred foods as ordered, for 1 of 1 resident with visual impairment (Resident #6), which resulted in Resident #6 having difficulty feeding himself and missing preferred foods. The findings included: Resident #6 was readmitted 4/15/2025 with diagnoses including heart failure, kidney disease, gastro-esophageal reflux disease, dysphagia (trouble swallowing), Barrett's esophagus (inflammation of the esophagus), macular degeneration and legal blindness. The most recent quarterly Minimum Data Set Assessment (MDS) dated 8/22/2025, indicated Resident #6 was cognitively intact. He required supervision for set up with eating. The Care Plan revised on 10/5/2023 for Resident #6, showed for the focus area of impaired vision related to macular degeneration and legal blindness revised on 10/05/2023, the goal was no decline of visual function with a target of 11/14/2025. Interventions included to tell Resident #6 where items were being placed and to be consistent with placement of items. The Care Plan revised on 12/28/2023, with a target date of 8/28/2025, showed for the focus area of ADL Self	F0810	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. F810 For dietary services, a corrective action was obtained on 9/22/2025 and 9/24/2025. Based on observation, record review, and interviews the facility failed to provide adaptive equipment and diet preferences as care planned for 1 of 1 residents reviewed. Resident #6 adaptive equipment needs were reviewed by the Director of Rehab and the facility Occupational Therapist on 9/24/2025. Orders, meal ticket, and care plan was reviewed by Minimum Data Set Coordinator on 9/24/2025. Orders, meal ticket and care accurately reflected therapy and dietary recommendations. On 9/24/2025 facility Nurse Practitioner ordered labs to review nutrition and hydration stratus. No adverse effects were noted. On 10/10/2025 IDT reviewed Resident #6 for weight loss. No significant weight loss was noted. 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 9/24/2025 Director of Rehab and facility Occupational Therapist reviewed all residents to assess adaptive equipment needs. On 10/10/2025 all orders, meal tickets, and care plans were updated to reflect therapy recommendations.	11/20/2025

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F0810 SS = D	Continued from page 12 Care Performance, the goal was that Resident #6 will maintain his current level of functioning for eating. Intervention was for him to feed himself with set up and assistance as needed. The Care Plan dated 8/12/2025 showed with the focus area of potential nutritional problems and fluctuations in weight, included the goal for Resident #6 to maintain weight. The intervention included him to receive all food in separate bowls to distinguish foods, due to poor vision. The current diet order dated 04/28/2025, revealed: No Added Salt (NAS) diet, soft & bite-sized texture, thin consistency, all food in bowls, two milks with lunch. Family requests no sandwiches (all other breads are OK). On 9/22/2025 at 1:10 PM an observation of a sign posted above Resident #6's bed stated: "Resident is visually impaired. Caregivers Must: 1) Announce tray arrival, 2) Describe food in bowls, 3) Open condiment packets, 4) Ask how else you can help, 5) Ask if patient is finished before removing tray." Resident #6's Tray Card showed- Diet Order: Soft/Bite Sized, NAS; Adaptive Equipment: All Food in Bowls; Notes: Vanilla Cream, Always Send Bowl of Peanut Butter Crackers, Send Milk, Mashed Potatoes No Gravy; Standing Orders: 8 ounces (oz.) of Whole Milk and 8 oz. of Water. On 09/22/2025 at 1:00 PM during an interview, Resident #6 stated it's easier to eat with food in bowls so he can scoop around with the spoon on the sides of the bowl, and the food doesn't run away from him. During an observation and interview with Resident #6 on 9/24/2025 at 6:00 PM, the meal consisted of an uncut, whole cheese sandwich which was served on a plate, and soft-cooked squash pieces in bowl. Resident #6 stated he doesn't eat whole sandwiches because they are too hard to pick up. On 09/25/2025 at 12:42 PM an observation of Resident #6's lunch revealed Nurse #7 delivered Resident #6's tray. The meal was in bowls except for a piece of cake	F0810	Continued from page 12 Systemic changes In-service education began on 10/1/2025 by the Director of Rehab Services to all full time, part time, and as needed staff nursing and dietary staff. Topics included: Purposes of Adaptive Equipment Process for assessing and ordering adaptive equipment in Point Click Care (PCC) and PCC Tray Card. 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. Quality Assurance monitoring procedure. The Dietary Service Director, Director of Rehab Services and Director of Nursing will monitor procedures for providing adaptive equipment weekly x 4 weeks then monthly x 2 months using the QA Audit which will include reviewing meal trays at each meal to ensure adaptive equipment provided as ordered. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Director of Rehab Services, Health Information Manager, and the Dietary Manager Completion Date: 11/20/2025	

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F0810 SS = D	Continued from page 13 on a plate, and there was one carton of milk. Nurse #7 didn't offer to open the condiments. Resident was observed to have taken a few bites of cake from plate with a spoon and had difficulty getting the cake on the spoon because it would fall off. The resident then ate part of the cake with his fingers. An interview with Nurse #7 on 09/25/2025 at 12:45 PM revealed she hadn't delivered a tray to Resident #6 before and wasn't aware specifically of his need for food in bowls. In an interview with the Dietary Manager on 09/25/2025 at 3:36 PM she stated that when an order read for all food items to be in a bowl, that means everything and that sandwiches were cut and placed in a bowl. She further said that when asked why Resident #6 did not get all the items in bowls as ordered, she said that her staff were nervous and made mistakes. When asked why he did not get 2 milks with his lunch tray as ordered, she looked at his meal ticket and said it was not on the Tray Card. She looked more closely at the Tray Card and admitted it was written in a confusing way on the card with "send milk" in notes section and "whole milk" in the standing orders section. During an interview with Nurse #3 on 09/25/2025 at 4:04 PM, she stated that she has brought Resident #6 his tray at all three mealtimes and he had gotten 1 carton of milk at each meal. During an interview with the Director of Nursing (DON) on 9/25/2025 PM at 4:21 PM, when questioned what the staff should do if Resident #6's food wasn't in bowls, she indicated staff should take the tray back to the kitchen and get it in bowls to make sure he can access the food. She elaborated that if a tray ticket has something listed that was missing, they were expected to retrieve it from the kitchen.	F0810		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or	F0812	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.	11/20/2025

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F0812 SS = F	Continued from page 14 considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to: label and date leftover food stored for use in 1 of 1 walk-in cooler and 1 of 1 walk-in freezer and discard food showing signs of spoilage or past its use-by date in the walk-in cooler; monitor dish machine temperatures; and maintain a clean kitchen ice machine. These practices had the potential to affect food served to residents. The findings included: a. During an initial observation of the facility's kitchen with the Assistant Dietary Manager on 9/22/2025 at 10:36 AM, the walk-in cooler was noted to have the following concerns: -An opened and unlabeled 5-pound (lb.) bag of fancy shredded cheese. -An opened and unlabeled 5-pound (lb.) bag of romaine lettuce with signs of spoilage (brownish/ blackish in color lettuce leaves with thickened clear fluid). -A bag of diced strawberries with an open date of 9/10/2025 and a discard date of 9/10/2025 available for use. -Three (3) of 7 bell peppers showing signs of spoilage (black/ grayish looking spots, mushy texture with clear liquid).	F0812	Continued from page 14 F812 For dietary services, a corrective action was obtained on 9/22/2025 During initial walk through of the kitchen on 9/22/2025, it was noted dietary services had failed to properly label, date, or discard expired food. On 9/22/2025 the Assistant Dietary Manager discarded all improperly stored, unlabeled, and expired food items. During 9/25/2025 observation of kitchen task the dish machine gauge failed to show required temperature and ice machine noted with buildup. Internal thermometer used to assess temperature and allowed dish machine to be utilized until gauge fixed. Usage of ice machine stopped until service could be completed. 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 09/23/2025, the Dietary Consultant completed a kitchen and nourishment walk through with the Dietary Manager to ensure all food items were stored properly. Dish machine serviced 9/26/2025 and ensured to be in working order. Ice machine was scheduled for service on 10/2/2025. Ice machine service was completed on 12/2/2025. On 9/23/2025 Environmental Services Manager purchased a thermometer for the kitchen. Systemic changes In-service education was provided to all full time, part time, and as needed dietary staff on 10/1/2025 by the Corporate Dietician, Regional Director of Operations and Regional Dietary Services Manager. Topics included:	

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F0812 SS = F	Continued from page 15 b. During an initial observation of the facility's kitchen with the Assistant Dietary Manager on 9/22/2025 at 10:45 AM the walk-in freezer was noted to have the following concerns: -An open, unlabeled package of chicken strips with signs of dehydrated spots, discolored patches, leathery spots. -An open, unlabeled package of hot dogs with signs of dehydrated spots, discolored patches, leathery spots. -One (1) box of open, unlabeled package of sausage patties with signs of dehydrated spots, discolored patches, leathery spots. -Two (2) boxes of open, unlabeled chocolate chip cookies with signs of dehydrated spots, discolored patches, leathery spots; and -One (1) box of open, unlabeled sugar cookies with signs of dehydrated spots, discolored patches, leathery spots. An interview with the Assistant Dietary Manager on 9/22/2025 at 10:43 AM revealed that she understood that items were not stored correctly. The Assistant Dietary Manager disposed of food items. The Assistant Dietary Manager stated that labels and dates on open food items should be checked weekly. She further stated the items in the walk-in freezer should not be open and needed to be discarded. An interview with the Administrator on 9/25/2025 at 1:22 PM revealed all food and beverage items should be dated when they are opened, food with signs of spoilage should be discarded, and food items should be used or discarded according to use-by policies. He further stated the dietary department was responsible for food storage and safety daily. c. During an observation of the facility's kitchen with the Dietary Manager on 9/25/2025 at 10:07 AM the dish machine was noted to have the following concerns: -1st wash cycle had 9 dome lids and 4 bottoms. The dish machine washing thermostat gauge froze to 120 degrees and did not move up or down. -2nd wash cycle at 10:10 AM had 6 trays and 5 dinner	F0812	Continued from page 15 Storage and dating policies and regulations. Inspections on shifts to observe all food are within their dates and tossed if out of date. Procedures for alerting person in charge/maintenance assistant when equipment out of working order. Sanitation processes in dish room. Proper thermometer handling, temperature monitoring, and log completion. Environmental Services Manager and Maintenance Assistant to maintain kitchen equipment using preventative maintenance management system through the Direct Supply TELS system. All full time, part time, and as needed dietary staff will complete the Healthcare Academy Courses Safe Food Handling and Kitchen Observation. This education will be completed by 12/5/2025. 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. Quality Assurance monitoring procedure. The Dietary Manager or assignee will monitor procedures for proper food storage, preparation, distribution, and service daily x2 weeks and weekly x4. Dietary Quality Assurance Tool which will observe that all food is labeled, dated, tempted correctly, and stored in clean and working equipment. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and 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, Health Information Manager, and the Dietary Manager.	

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F0812 SS = F	Continued from page 16 plates. The dish machine washing thermostat gauge froze to 120 degrees and did not move up or down. -3rd wash cycle at 10:11 AM had 9 plates and 11 small dishes. The dish machine washing thermostat gauge froze to 120 degrees and did not move up or down. An interview was conducted with Dietary Aide (DA) #1 on 9/25/2025 at 10:12 AM. DA #1 stated she was responsible for the clean side of the dish machine when the dishes come through and were being cleaned. She further stated that the temperatures for the dish machine were not working like it was supposed to. The DA revealed the dish machine washing thermostat gauge had not been working since last Tuesday, 9/16/25, and the Dietary Manager was aware. She further stated there was no other alternative method of checking the dishwashing temperatures. An interview with the Dietary Manager on 9/25/2025 at 10:25 AM revealed the dish machine was not functioning properly. The Dietary Manager stated the dish machine was a rental from an outside vendor and there had been issues with the dish machine for some time. The Dietary Manager stated since the dish machine was a rental from an outside vendor, the Maintenance department could not complete repairs. The Dietary Manager explained the outside vendor did not have an assigned representative assigned to the facility and would send a representative to the facility when available. The Dietary Manager immediately notified the outside vendor of the washing gauge on the dish machine and the gauge not capturing the temperatures of the washing cycles. The Dietary Manager advised the dietary staff not to utilize the dish machine. An interview was conducted with the Administrator on 9/25/2025 at 1:22 PM. The Administrator stated the dish machine was checked on 9/24/2025 and he was unaware of any issues remaining with the dish machine and the washing thermostat gauge not working. The Administrator stated dietary staff should monitor the wash/ rinse cycle temperatures while the dish machine was in use. The Administrator further stated if the in-house maintenance staff cannot fix the dish machine, then the vendor would be called. d. During an observation of the facility's kitchen with the Dietary Manager on 9/25/2025 at 10:20 AM in the kitchen, the white interior cover of the ice machine	F0812	Continued from page 16 Completion Date: 11/20/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345503	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nsg and Rehab Ctr of Rowan County	**4412 South Main Street , Salisbury, North Carolina, 28147**

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F0812 SS = F	Continued from page 17 was covered with blackish film-like matter. An interview was conducted with the Dietary Manager and the Assistant Dietary Manager on 9/25/2025 at 10:20AM revealing the ice machine just recently received service. The Dietary Manager stated the white piece in the ice machine was stained and needed replacement. The Dietary Manager used her finger to show the staining, and the black film type matter was removed with her finger. The Dietary Manager and Assistant Dietary Manager stated they would not use the ice machine until it was serviced. An interview with the Administrator on 9/25/2025 at 1:22 PM revealed he expected the ice machine to be clean. The Administrator further revealed the ice machine was no longer going to be used until cleaned.	F0812		