

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Liberty Commons Nursing and Rehabilitation Center of Halifax County			STREET ADDRESS, CITY, STATE, ZIP CODE 101 Caroline Avenue , Weldon, North Carolina, 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 11/23/25 through 11/25/25. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID# 1DBEBD-H1.	E0000		12/12/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/23/25 through 11/25/25. Event ID# 1DBEBD-H1. The following intake was investigated: 842644. 1 of 1 the complaint allegation did not result in deficiency.	F0000		12/12/2025
F0628 SS = A	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals;	F0628		12/12/2025

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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F0628 SS = A	<p>Continued from page 1</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.</p> <p>§483.15(c)(3) Notice before transfer.</p> <p>Before a facility transfers or discharges a resident, the facility must-</p> <p>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p>	F0628		

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F0628 SS = A	<p>Continued from page 2 (E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice.</p> <p>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p>	F0628		

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F0628 SS = A	<p>Continued from page 3</p> <p>§483.15(c)(8) Notice in advance of facility closure</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.</p> <p>§483.21(c)(2) Discharge Summary</p> <p>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:</p> <p>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab,</p>	F0628		

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F0628 SS = A	<p>Continued from page 4 radiology, and consultation results.</p> <p>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.</p> <p>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record reviews and staff interviews, the facility failed to notify the Ombudsman in writing of a resident's transfer to the hospital for 1 of 2 residents reviewed for hospitalization (Resident #6).</p> <p>The findings included:</p> <p>Resident #6 was admitted to the facility on 5/19/22.</p> <p>The quarterly Minimum Data Set assessment dated 7/3/25 revealed Resident #6 was severely cognitively impaired.</p> <p>Review of Resident #6's progress notes revealed Resident #6 was transferred to the hospital on 7/30/25 and returned to the facility on 8/6/25.</p> <p>Review of Resident #6's medical records revealed no documentation in the medical record that the Ombudsman was notified of the reason for the transfer to the hospital.</p> <p>An interview was completed on 11/25/25 at 1:13pm with the Social Worker. The Social Worker stated she ran a monthly report of all residents that were discharged from the facility to send to the Ombudsman. The Social Worker revealed when she completed the July 2025 residents discharged from the facility report, she mistakenly did not include the residents that were discharged to the hospital and that was the reason for why the Ombudsman was not notified of Resident #6's transfer to the hospital.</p> <p>An interview was completed on 11/25/25 at 1:18pm with the Administrator. The Administrator revealed it was the Social Worker's responsibility to notify the</p>	F0628		

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F0628 SS = A	Continued from page 5 Ombudsman of a Residents' transfers from the facility each month. The Administrator revealed it was an error when running the monthly resident discharge report.	F0628		
F0803 SS = D	<p>Menus Meet Resident Nds/Prep in Adv/Followed</p> <p>CFR(s): 483.60(c)(1)-(7)</p> <p>§483.60(c) Menus and nutritional adequacy.</p> <p>Menus must-</p> <p>§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;</p> <p>§483.60(c)(2) Be prepared in advance;</p> <p>§483.60(c)(3) Be followed;</p> <p>§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;</p> <p>§483.60(c)(5) Be updated periodically;</p> <p>§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and</p> <p>§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record reviews, and interviews with staff, the facility failed to follow the approved menu for 2 of 4 residents on a pureed diet (Residents #18 and #38).</p> <p>The findings included:</p> <p>The Week 1 dietitian approved menu indicated residents on a pureed diet were to receive a #6 scoop (equal to 5.3 ounces) of pureed vegetable chili and a #10 scoop (equal to 3.25-4 ounces) of pureed cornbread.</p>	F0803	<p>1. How corrective action was accomplished for the residents found to have been affected by the deficient practice.</p> <p>The Dietary staff re-education was initiated on 12/17/2025 by the administrator regarding using appropriate scoop size according to recipe.</p> <p>Scoops of various sizes were ordered on 11/25/2025 by dietician. Re-education of dietary staff was initiated by administrator 12/17/2025 on following the recipe with all required ingredients, if any substitutions are needed, they must be approved by registered dietician; and to give residents on a pureed diet, pureed bread as indicated on menu whether prepared in-house or from approved vendor.</p> <p>2. How the facility identified other residents having the potential to be affected by the deficient practice.</p> <p>The registered dietician completed a 100% review of all residents receiving pureed diets on 12/17/2025 to verify that meals served were consistent with approved menus, standardized recipes, and portion requirements. No additional residents were identified as receiving non-compliant meals.</p> <p>3. Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not reoccur.</p> <p>Dietary staff re-education was initiated on 12/17/2025 by the administrator on the following:</p> <p>Menu compliance, standardized recipe adherence and correct scoop sizes and portion control.</p> <p>On 12/17/2025 a Color Coded display of scoop sizes was posted by administrator to indicate approved scoop sizes within the kitchen.</p> <p>All newly hired dietary staff will receive education in orientation on menu compliance, standardized recipe adherence and correct scoop sizes and portion control.</p> <p>The facility will ensure consistent availability of pureed bread options either prepared in-house or obtained through approved vendor.</p> <p>4. How the facility plans to monitor performance to</p>	12/19/2025

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F0803 SS = D	<p>Continued from page 6</p> <p>The Diet Report dated 11/24/25 documented 4 residents had orders for a pureed diet.</p> <p>a. Resident #18 was admitted to the facility on 2/05/20 with diagnoses including dysphagia (trouble swallowing), hospice care, and weight loss.</p> <p>Resident # 18's current physician orders reviewed 11/24/25 documented she was to receive a pureed no added salt diet.</p> <p>b. Resident #38 was admitted to the facility on 5/25/21 with diagnoses including dysphagia.</p> <p>Resident #38's physician orders dated 1/10/25 documented she was to receive a pureed cardiac diet.</p> <p>Observation on 11/24/25 at 12:05 PM revealed Cook #1 served one 4-ounce scoop of chili and one 4-ounce scoop of pureed greens to 2 residents on a pureed diet. There was no pureed cornbread or bread served on the trays. The pureed chili was a brown and gray color, and the regular chili was a bright red color.</p> <p>In an interview on 11/24/25 at 12: 07 PM, Cook #1 said the pureed chili contained only beef and beans and she did not put the vegetables in while preparing the pureed chili, which was why the two dishes were different colors. She stated not adding the vegetables would make the pureed chili taste better. She stated she used a 4-ounce scoop because she thought that was what the menu had indicated to use. She stated she forgot to make pureed cornbread or a bread item to serve.</p> <p>In an interview on 11/24/25 at 12:09 PM, the Certified Dietary Manager (DM) confirmed Cook #1 did not serve a pureed bread option and after surveyor intervention, asked her to make some for service. She stated normally she ordered premade pureed bread which meant the cooks did not routinely have to make it. She stated she was unable to order premade pureed bread on the last order due to a cost increase. The DM was unable to find a #6 scoop for the pureed chili and, after surveyor intervention, she gave Cook #1 a 6-ounce ladle to serve the chili. The DM was not aware the vegetables were not added to the pureed chili and stated they should have been as per the recipe.</p> <p>In a phone interview on 11/24/25 at 12:14 PM, the Registered Dietitian stated a pureed bread option should have been served, and the scoop size should have been followed per the menu. The recipe, which called</p>	F0803	<p>Continued from page 6</p> <p>make sure the solutions are sustained for ongoing compliance.</p> <p>The Certified Dietary Manager or designee will conduct meal tray observations for pureed diets daily for 14 days, then 3 times a week for 2 weeks then weekly for an additional 4 weeks.</p> <p>The Registered Dietitian will review findings monthly.</p> <p>Results will be reported to the Monthly Quality Assurance Process Improvement (QAPI) Committee, with immediate corrective action for any identified deficiencies.</p> <p>5. Date of compliance: 12/19/2025</p>	

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F0803 SS = D	Continued from page 7 for vegetables to be put into the pureed chili the same as the regular chili, should have been followed so residents on a pureed diet received the same menu item. She stated the menu should have been followed to ensure residents received enough calories in their meals.	F0803		