STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345367	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Healthcare Services of Golden Years Nursing Center, LLC	**7348 North West Street , Falcon , North Carolina, 28342**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/17/2025 through 11/20/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1DB788-H1	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/17/2025 through 11/20/2025. Event ID#1DB788-H1. The following intakes were investigated: 2671674, 2592566,856036, 856033,856032,856028,856027,856022,856021,856020,856019 19 of the 19 complaint allegations did not result in deficiency.	F0000		
F0640 SS = A	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F0640		12/09/2025

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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F0640 SS = A	Continued from page 1 §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to complete a discharge Minimum Data Set (MDS) for 1 of 33 residents sampled for assessments (Resident#9). Findings included: Resident #9 was admitted to the facility on 05/01/24 and was discharged to the hospital on 09/11/25 with diagnoses including chronic kidney disease.	F0640		

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F0640 SS = A	Continued from page 2 The quarterly MDS dated 07/27/25 had Resident #9 coded as moderately cognitively impaired. A discharge MDS was not found in Resident #9's Electronic Medical Record (EMR). A social services note dated 09/16/25 revealed Resident #9's two sons came to get their mother's personal belongings. An interview with the MDS nurse was conducted on 11/20/25 at 9:14 AM. She stated Resident #9 was discharged to the hospital from the facility and did not return. A discharge MDS was required to be completed. The assessment was missed. The MDS nurse also stated the MDS consultant sends her a list of every MDS that should have been completed every quarter, but the quarter had not ended. An interview with the Administrator was conducted on 11/20/25 at 11:47 AM. She stated she expected a discharge MDS assessment to be completed at discharge for all residents.	F0640		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F0641	F641 Accuracy of Assessments For resident # 12 a corrective action was obtained on 11/20/25 by modifying and submitting to CMS a correction to the Minimum Data Set MDS) assessment for assessment reference date (ARD) of 9/1/2025 Coding of question I5800 Depression to accurately reflect the diagnosis of depression. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents with a diagnosis of depression have the potential to be affected by the alleged deficient practice. Audit Results: Minimum Data Set record were reviewed using the MDS validation reports for the last two weeks. Batch reports from 11/21/25 through 12/5/25 reviewed. 1 of 8 residents reviewed were found with deficient practice. Systemic Changes On 12/08/2025, the Clinical Reimbursement Consultant completed an in-service training for the facility	12/09/2025

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F0641 SS = D	Continued from page 3 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review and staff interviews, the facility failed to accurately code the Quarterly Minimum Data Set (MDS) assessment for 1 of 33 sampled residents reviewed for diagnosis of depression. (Resident #12) Findings included: Resident #12 was admitted to the facility on 06/24/2024. Cumulative diagnoses included hypertension, diabetes mellitus, depression and hyperlipidemia. Review of the August 2025 Medication Administration Record (MAR) revealed Resident #12 received the medication Sertraline (antidepressant medication) tablet 25 Milligram (MG) 1 tablet by mouth one time a day for depression. Review of the Quarterly Minimum Data Set (MDS) assessment dated 09/01/2025 indicated Resident #12 was cognitively intact. MDS Section I5800 under the active diagnoses was documented as no for Resident #12 having an active diagnosis of depression. During an interview with the Director of Nursing (DON) on 11/20/2025 at 9:14 AM, she confirmed that the resident's MDS was inaccurate due to the resident having a diagnosis of depression and was receiving antidepressant medication. The DON further stated that it was her expectation that the MDS would be coded accurately. During an interview with the MDS Coordinator on 11/20/2025 at 10:15 AM, she confirmed Resident#12 had diagnosis of depression and the MDS was not coded accurately. MDS Coordinator added that she will be	F0641	Continued from page 3 Minimum Data Set (MDS) nurse(s) that included the importance of thoroughly reviewing the medical record for diagnosis of depression. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will review Minimum Data Set Assessments for 5 residents for accuracy of coding of MDS items utilizing the Accurate Coding of MDS Audit Tool. This audit will be done weekly x 3 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 12/9/25	

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F0641 SS = D	Continued from page 4 careful next time to make sure the MDS was coded accurately. During an interview with the Administrator on 11/20/2025 at 10:35 AM, she stated the MDS was not accurate because the resident had diagnosis of depression. She added her expectation was the MDS is coded accurately for the residents.	F0641		