

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/30/2013
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NAME OF PROVIDER OR SUPPLIER LIBERTY CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539
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(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
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{F 000}	INITIAL COMMENTS An offsite revisit was conducted and based on the acceptable POC the facility was deemed to be in compliance as alleged on 11/30/13.	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.

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F 000 INITIAL COMMENTS

A Standard Recertification Survey was initiated on 10/29/13 and concluded on 10/31/13 with deficiencies cited. The highest scope and severity was an "E".

F 253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff and resident interviews, and review of facility policy, it was determined the facility failed to maintain a proper sanitary environment related to improper storage of residents' bath basins and bed pans for three (3) unsampled residents. A bedpan was observed to be unlabeled and uncovered in Unsampled Resident #1's bathroom. An unlabeled and unbagged collection hat was lodged between a towel bar and the wall in Unsampled Resident #2's bathroom, and an unlabeled bed pan was stored in the bathroom of Unsampled Resident #3.

The findings include:

Review of facility policy entitled, "Policies and Practices- Infection Control", with a revision date of August 2012, revealed "This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections".

F 000 This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F 253

F 253
On 10/29/13, the unlabeled and uncovered bed pan was discarded for unsampled Resident #1. The unlabeled and unbagged collection hat was discarded for unsampled Resident #2. The unlabeled bed pan was discarded for unsampled Resident #3. All items were replaced new, labeled with the residents name, bagged and properly stored.

11/25/2013

The Unit Managers will conduct rounds in all the resident rooms and bathrooms daily for one week, then one time a week for one month and then monthly for three months, to assure all bed pans collection hats are properly labeled and stored on 10/30/2013. Any items found unlabeled and uncovered were discarded, replaced new, labeled with the residents name, bagged and properly stored.

The Staff Development Coordinator conducted in-services those in-services were complete with all Nursing Staff from 11/1/2013- 11/25/2013 on proper labeling

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrative* (X9) DATE: *11/21/13*

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.

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F 253 Continued From page 1

Observations on 10/29/13 at 10:00 AM, 10:25 AM, and 10:32 AM in three (3) unsampled resident rooms revealed the following: an uncovered bath pan with no identifying name in the bathroom of Unsampled Resident #1; an unlabeled and uncovered collection hat wedged between the towel bar and the wall in the bathroom belonging to Unsampled Resident #2; and an unlabeled bed pan stored in Unsampled Resident #3's bathroom.

Interview with Licensed Practical Nurse (LPN) #3, on 10/29/13 at 10:15 AM, revealed bath basins were to be stored in the resident's bedside table, after being labeled with the resident's name and placed in a plastic bag.

During Interview with Certified Nursing Assistants (CNA) #4 and #5, on 10/29/13 at 10:20 AM, CNA #5 confirmed the collection hat in Unsampled Resident #2's bathroom was not labeled and was uncovered. CNA #4 stated the collection hat was intended for one-time use to collect a urine sample, and should not have been stored in the bathroom. She further stated bed pans and urinals should be labeled and bagged for storage in the bathroom. During continued interview, CNA #5 stated bath basins should be labeled with the resident's name and room number, bagged and stored in the bedside table.

Interview with Registered Nurse (RN) #1, on 10/29/13 at 10:37 AM, revealed she would not be able to identify an unlabeled bed pan. She stated it was the facility's process to label bed pans with the first initial and last name and room number. RN #1 further stated she could not tell who the unlabeled bed pans in the bathrooms for

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and storage of bath basins, bed pans, and collection hats to ensure proper storage of such items are followed.

The Unit Managers and Weekend Supervisor and /or Director of Nursing will conduct rounds to ensure proper labeling and proper storage is maintained. The Unit Managers and Weekend Supervisor will report any findings and corrective action to the Director of Nursing and/or the Administrator.

The Director of Nursing and/or the Administrator will make weekly rounds for one month, and then monthly for one quarter to ensure proper storage and labeling are maintained to ensure a sanitary environment. The results of the rounds will be reviewed and analyzed monthly for three months and the quarterly or as needed at the Quality Assurance Performance Improvement Committee meeting to assure a sanitary, orderly and comfortable environment are maintained.

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F 253	Continued From page 1 Observations on 10/29/13 at 10:00 AM, 10:25 AM, and 10:32 AM in three (3) unsampled resident rooms revealed the following: an uncovered bath pan with no identifying name in the bathroom of Unsampled Resident #1; an unlabeled and uncovered collection hat wedged between the towel bar and the wall in the bathroom belonging to Unsampled Resident #2; and an unlabeled bed pan stored in Unsampled Resident #3's bathroom. Interview with Licensed Practical Nurse (LPN) #3, on 10/29/13 at 10:15 AM, revealed bath basins were to be stored in the resident's bedside table, after being labeled with the resident's name and placed in a plastic bag. During Interview with Certified Nursing Assistants (CNA) #4 and #5, on 10/29/13 at 10:20 AM, CNA #5 confirmed the collection hat in Unsampled Resident #2's bathroom was not labeled and was uncovered. CNA #4 stated the collection hat was intended for one-time use to collect a urine sample, and should not have been stored in the bathroom. She further stated bed pans and urinals should be labeled and bagged for storage in the bathroom. During continued interview, CNA #5 stated bath basins should be labeled with the resident's name and room number, bagged and stored in the bedside table. Interview with Registered Nurse (RN) #1, on 10/29/13 at 10:37 AM, revealed she would not be able to identify an unlabeled bed pan. She stated it was the facility's process to label bed pans with the first initial and last name and room number. RN #1 further stated she could not tell who the unlabeled bed pans in the bathrooms for	F 253	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> The Unit Managers and Weekend Supervisor and /or Director of Nursing will conduct rounds to ensure proper labeling and proper storage is maintained. The Unit Managers and Weekend Supervisor will report any findings and corrective action to the Director of Nursing and/or the Administrator. The Director of Nursing and/or the Administrator will make weekly rounds for one month, and then monthly for one quarter to ensure proper storage and labeling are maintained to ensure a sanitary environment. The results of the rounds will be reviewed and analyzed monthly for three months and the quarterly or as needed at the Quality Assurance Performance Improvement Committee meeting to assure a sanitary, orderly and comfortable environment are maintained.		

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F 253 F 322 SS=D	Continued From page 2 Unsamped Residents #1 and #3 belonged to 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and record reviews, it was determined the facility failed to properly label the tube feeding bottle for one (1) of eighteen (18) residents (Resident #1). The findings include: No policy was provided by the facility.	F 253 F 322	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	11/9/2013
			F 322 On 10/29/13, Resident # 1 Glucerna feeding bottle was changed and labeled with the resident's name, time, date, room number and rate. The flush water bottle was changed, labeled with name, time, date, room number and flush rate. The Unit Mangers reviewed all other residents who are fed by gastrostomy tube on 10/29/2013 to ensure the tube feeding and flush water were labeled with appropriate date, time room number and flush rate. There were no other tube feeding or flush water to be unlabeled found. The Director of Nursing and the Staff Development Coordinator completed in-services with all the Licensed Nurses completed on 11/5/2013 regarding proper	

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F 322	Continued From page 3 Review of the clinical record revealed Resident #1 was admitted by the facility on 04/05/13 with diagnoses which included Diabetes Mellitus II, Paralytic Ileus, and Dysphagia. Review of the Physician's Order, dated 09/13/13, revealed Resident #1 was to receive Glucerna 1.2 tube feeding via an infusion pump at sixty (60) milliliters per hour for twenty-two (22) hours, and the system was to be flushed at the rate of two hundred (200) milliliters every eight (8) hours. Further review of the physician's order revealed the formula container was to be labeled with the resident's name, date, time and nurse's initials. Observation, on 10/29/13 at 10:06 AM, revealed Resident #1's Glucerna feeding bottle was not labeled with the time, date, or room number. Further observation revealed the flush water bottle had not been labeled with the time, date, room number, or rate of flush. During interview with licensed Practical Nurse (LPN) #3, on 10/29/13 at 10:15 AM, she confirmed the tube feeding bottle and the water flush bottle for Resident #1 was not labeled with the required information. She stated the person who hung the bottles failed to label them correctly. Continued interview revealed the bottles should have been labeled with the resident's name and room number, the date, and the infusion rate.	F 322	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> labeling of tube feeding and flush water to include: residents name, time, date, room number and rate. The nurses will be completing rounds at shift change to ensure proper labeling is in place and the rate are in accordance to physicians orders. The Unit Managers, Weekend Supervisor and/or Director of Nursing will conduct audits on a daily basis for one week, then one time a week for one month and then monthly for three months to assure the licensed nurses are properly labeling the tube feeding and flush water per physicians orders. The Director of Nursing will report any findings/patterns for three months, then Quarterly or as needed at the Quality Assurance Performance Improvement Committee Meeting to assure the proper labeling is in place and the rate are in accordance to physicians orders.		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441			

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F 441	Continued From page 4 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as Isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of Infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on Interview, record review, and review of facility policy it was determined the facility failed to maintain an effective Infection Control Program	F 441	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F441 On 10/30/13 the appropriate PPE gown and gloves were donned prior to entering the contact precaution room for resident # 2. On 10/29/13 the Mechanical Lift was sanitized before use with any other residents. On 10/31/13 the appropriate protocol for changing gloves, hand washing and appropriate measures for handling soiled linen were executed. On 10/29/13 the appropriate infection control measures were executed when delivering meal trays to contact precaution rooms. LPN #4, CNA #1, 4, 7 and 8 involved were each educated regarding appropriate PPE, sanitizing equipment, proper hand washing, gloving procedures and handling soiled linen on 11/4/13. The Unit Managers, Infection Control Nurse and/or Director of Nursing completed rounds in all isolation rooms to assure the proper PPE were available to the staff on 10/31/13. All residents are at risk. The Infection Control Committee had an Ad	11/30/2013	

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F 441 Continued From page 5

designed to provide a safe and sanitary environment and to prevent the development and transmission of disease and infection for the facility as evidenced by observation of direct care staff providing resident care without donning appropriate Personal Protective Equipment (PPE) for residents with Contact Isolation Precautions in place. Observations of meal tray delivery into a Contact Isolation room revealed PPE was not being utilized. Additionally observation revealed a Hoyer lift removed from a Contact Isolation room without being properly sanitized; and, staff removing soiled trash/linen bags from a Contact Isolation room without wearing gloves for four (4) of nineteen (19) sampled residents (Resident residents in a selected sample of Nineteen (19).

The findings include:

Review of the facility's policy titled, "Policies and Practices- Infection Control", Policy Statement Page 18, with a revision date of 08/12 revealed the facility's infection control policies and procedures were intended to facilitate the maintenance of a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.

Review of the facility's policy titled, "Isolation-Categories of Transmission-Based Precautions" with a revision date of 08/12, revealed contact precautions were to be implemented for residents known or suspected to be infected with microorganisms that could be transmitted by direct contact with the resident or indirect contact with environmental surfaces. The policy indicated examples of infections requiring contact precautions included, but were not limited to: infections with multi-drug resistant organisms.

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hoc meeting on 11/12/13 to review Infection Control and Isolation-Categories of Transmission-Based Precautions. The Staff Development Coordinator/Infection Control Nurse completed in-service with all staff between 11/1/2013- 11/25/2013 for donning appropriate PPE for resident in Contact Isolation, proper sanitation of equipment used in Contact Isolation rooms, hand washing, gloving and proper removal of soiled linen from the Contact Isolation room- to ensure an effective infection control program to provide safe and sanitary environment and to prevent the transmission of disease and infection.

The Unit Managers, Weekend Supervisor and/or Infection Control nurse will conduct audits on a daily basis for one week, then one time a week for one month and then monthly for three months to assure staff are donning appropriate PPE, sanitizing equipment, hand washing, gloving and handling soiled linens appropriated for Contact Isolation rooms. Any concerns will be addressed immediately including any needed education, and reported to the Infection Control Committee for further

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F 441	<p>Continued From page 6</p> <p>Further review of the policy revealed if a resident was placed in contact precautions, in addition to wearing gloves, staff were to wear a disposable gown upon entering the room.</p> <p>1. Review of Resident #2's record revealed an admission date of 12/3/2009, with diagnoses which included Type II Diabetes Mellitus, Pressure Ulcers to the Heel and Buttock, and MRSA (Methicillin-resistant Staphylococcus aureus, an antibiotic resistant organism). Review of the Quarterly Minimum Data Set, (MDS) Assessment dated 9/16/2013, revealed the facility assessed Resident #2 to have severe cognitive impairment and to require extensive assist from staff for all Activities of Daily Living.</p> <p>Observation on 10/30/13 at 5:30 PM, revealed Certified Nursing Assistant (CNA) #4 entered the room of Resident # 2, who was on contact precautions, without donning gloves and a gown as per facility policy.</p> <p>Interview, on 10/30/13 at 5:35 PM, with CNA #4 revealed she did "usually" put on gloves and a gown before entering Resident #2's room and had been trained to do this. CNA# 4 stated she should have donned gloves and a gown prior to entering Resident #2's room as per facility policy.</p> <p>Interview, on 10/30/13 at 5:40 PM, with Licensed Practical Nurse (LPN) #1 revealed CNA #4 had entered Resident #2's room without donning gloves or a gown; however, the CNA had been trained on contact precautions and knew to do this prior to entering a room with contact precautions.</p> <p>2. Review Resident #10's record revealed an</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>review and recommendations. The Director of Nursing and the Administrator will observe infection control practices as part of their weekly rounds and any concerns will be corrected and addressed immediately, including education.</p> <p>The Infection Control Committee will continue surveillance and observation, track and trend infections, make recommendations to prevent the transmission of disease and infection. The Infection Control Nurse will report any findings/patterns for three months, then Quarterly or as needed at the Quality Assurance Performance Improvement Committee Meeting to ensure an effective infection control program to provide safe and sanitary environment and to prevent the transmission of disease and infection.</p>	

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NAME OF PROVIDER OR SUPPLIER LIBERTY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539		
(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 441	<p>Continued From page 7</p> <p>re-admission date of 09/28/13, with diagnosis which included Congestive Heart Failure. Review of the lab report dated 10/18/13, revealed Resident #10's urine contained ESBL (Extended Spectrum Beta-Lactamase) bacteria causing urinary tract infections and are resistant to some antibiotics).</p> <p>Observation on 10/29/13 at 12:25 PM, revealed LPN #4 coming out of Resident #10's room with a lift and not sanitizing the lift. Further observation revealed Resident #10 was on contact precautions.</p> <p>Interview, on 10/29/13 at 12:45 PM, with LPN #4 revealed she came out of Resident #10's room with the lift to take it to the facility's central bath storage area to sanitize it. She stated she was "sure" the CNAs had sanitized the lift while it was in Resident #10's room. LPN #4 stated she did not sanitize the lift while it was in Resident #10's room and by taking it from the room not sanitized there was a potential to infect other residents. She indicated she should have sanitized the lift prior to removing it from Resident #10's room.</p> <p>Interview, on 10/29/13 at 12:50 PM, with CNA #1 revealed if a lift is in a contact isolation room it needed to be sanitized while in the room.</p> <p>Interview, on 10/31/13 at 4:55 PM, with LPN #1 revealed hoist lifts should be sanitized prior to coming out of a contact isolation room. LPN #1 stated LPN #4 had indicated she have "just infected" everyone up and down the hall.</p> <p>Observation on 10/31/13 at 11:30 AM of CNA #8, while in a contact isolation room, revealed the CNA touched the bed and bed control with gloved hands then provided peri-care to Resident #16</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 8</p> <p>without changing gloves or washing hands. Observation of CNA #7, who was also in the room, revealed the CNA to pick up a plastic bag from Resident #16's bed with no gloves on, leave the room and proceed down the hall to the soiled linen room.</p> <p>Interview, on 10/31/13 at 3:35 PM, with CNA #8 revealed gloves were supposed to be changed before providing care if other items were touched, such as, the bed and bed control. CNA #8 indicated he/she had been told to treat contact isolation residents' roommates in the same manner by using gloves and gowns.</p> <p>Interview, on 10/31/13 at 4:25 PM, with Registered Nurse (RN) #1 revealed she did not think bags should be transported without gloves. She stated if a bag was placed on the bed of contact precaution resident it could become potentially contaminated with the organism the resident was infected with.</p> <p>3. Observation on 10/29/13 at 12:30 PM revealed CNA #1 took Resident #10's lunch tray into his/her room without donning personal protection equipment (PPE). Observation revealed Resident #10 was on contact precautions. Continued observation revealed CNA #1 to touch Resident #10's bedcovers and then touched the resident's hand with her ungloved hands.</p> <p>Interview, 10/29/13 at 12:32 PM, with SRNA #1 revealed she should have gownned and gloved before entering Resident #10's room and washed her hands after exiting the room.</p> <p>Interview, on 10/31/13 at 2:30 PM, with the Infection Control Nurse revealed prevention and</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER LIBERTY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539		
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F 441	Continued From page 9 control of additional cases of infection fell on educating staff, performing thorough hand washing, cleaning and sanitizing items the correct way, performing "proper" peri-care, and ensuring gloves were utilized correctly.	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

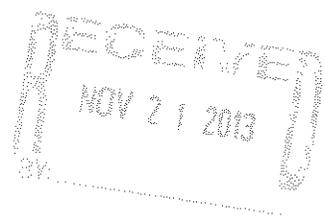
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185408	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 10/30/2013
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NAME OF PROVIDER OR SUPPLIER LIBERTY CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1993</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Six</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 10/30/13, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Norma Nikes</i>	TITLE <i>Administrative</i>	(X6) DATE 11/21/13
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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.