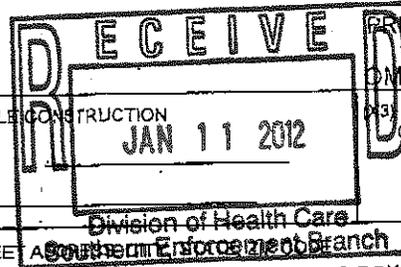


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 12/16/2011
FORM APPROVED
DMS NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETED 12/01/2011
NAME OF PROVIDER OR SUPPLIER LIBERTY CARE CENTER		STREET ADDRESS 816 S WALLACE WILKINSON BLVD, PO BOX 1435 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 000	INITIAL COMMENTS	F 000		
F 164 SS=D	<p>483.10(e), 483.75(i)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law, third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 164	Refer to Attachment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marella Hodges TITLE: Executive Director (X6) DATE: 12/26/11

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 team participation.

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F 164	<p>Continued From page 1</p> <p>by:</p> <p>Based on observation, interview, and record review, the facility failed to provide personal privacy during treatment for two of nineteen sampled residents. Resident #6 and Resident #10 were not provided privacy during skin assessments conducted on 11/30/11.</p> <p>The findings include:</p> <p>A review of the guidelines for the facility policy titled Quality of Life (dated 10/31/10) revealed privacy of the body was to be maintained and staff was to provide care in a manner that maintained each resident's dignity.</p> <p>1. On 11/30/11, at 9:35 AM, Licensed Practical Nurse (LPN) #4 was observed to conduct a skin assessment of Resident #6. The LPN failed to close the window blind/curtain to a window facing the facility front parking lot and the resident's groin area was exposed and in view of the window.</p> <p>An interview conducted with LPN #4 on 11/30/11, at 9:35 AM, revealed it was facility policy to close the blinds and pull the privacy curtain to provide privacy for the resident during the skin assessment. LPN #4 stated she forgot to close the blinds/curtain.</p> <p>2. Observation on 11/30/11, at 2:45 PM, revealed RN #1 (Evening Supervisor) conducted a skin assessment for Resident #10. Resident #10 was positioned in the bed located near the door. Observation of Resident #10's room revealed only one privacy curtain was present which encircled and provided personal privacy for the</p>	F 164		

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F 164	Continued From page 2 resident in the bed located next to the window. During Resident #10's skin assessment, facility staff knocked on the resident's door on two separate occasions and was permitted by RN #1 to open the door while the resident was partially undressed and exposed. Interview on 11/30/11, at 3:00 PM, with RN #1 revealed privacy should always be provided for residents during any procedure. RN #1 acknowledged privacy had not been provided during the skin assessment performed for Resident #10. RN #1 stated she was not aware a privacy curtain was not available to provide personal privacy for Resident #10 during the skin assessment. Interview on 11/30/11, at 3:00 PM, with the Housekeeping Supervisor (HS) revealed the privacy curtain in the resident's room had been removed on 11/29/11 for cleaning. The HS stated it was her responsibility to ensure privacy curtains were in every resident room and she failed to provide a replacement privacy curtain for Resident #10 from the facility's stock.	F 164			
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policy, the facility failed to	F 221			

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F 221	<p>Continued From page 3</p> <p>ensure one of nineteen residents was free from physical restraints (Resident #3). Documentation revealed a "Lap Buddy" restraint was to be used for Resident #3 due to the resident's medical diagnosis of Alzheimer's Dementia and the resident's inability to sit upright in a seated position. Physician's orders and the resident's Comprehensive Care Plan revealed the "Lap Buddy" restraint was to be removed during meals. However, observations revealed facility staff failed to remove the resident's "Lap Buddy" restraint during meals.</p> <p>The findings include:</p> <p>A review of the Restraint policy (dated April 2009) revealed a systematic and gradual process to reduce the use of restraints was in effect for each resident whose care plan indicated the need for restraints.</p> <p>A review of Resident #3's medical record revealed physician's orders dated 11/12/11 which indicated a "lap Buddy" restraint was to be used while the resident was up in a wheelchair due to the resident's diagnosis of Alzheimer's Disease with Dementia and the resident's inability to sit upright. The physician's order revealed the "lap buddy will be removed during meals." A review of the Comprehensive Care plan dated 10/06/11 revealed, "May remove the lap buddy during meals, activities of daily living care or as resident will allow." Further review of the CNA care plan indicated a "Lap buddy" was to be utilized for Resident #3 when the resident was sitting up in the wheelchair. The CNA care plan did not indicate when to remove the lap buddy.</p>	F 221		

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F 221	<p>Continued From page 4</p> <p>Observations on 11/29/11, at 7:06 AM, revealed Resident #3 was in the North Hall dining room seated at the dining table in a wheelchair with a lap buddy in place. A CNA (Certified Nursing Assistant) assisted the resident with the breakfast meal and, even though the CNA remained at the resident's side during the entire meal, the CNA did not remove the lap buddy. Observations on 11/29/11, at 10:05 AM and 10:50 AM, revealed the resident was seated in the hallway with the lap buddy in place. At 11:00 AM on 11/29/11, Resident #3 was assisted by staff to the bathroom and incontinence care was provided. The resident was then returned to the dining room and the lap buddy was observed to remain in place. At 12:10 PM on 11/29/11, the noon meal was delivered to Resident #3; the lap buddy remained in place on the wheelchair throughout the meal service even though CNA #8 was seated beside Resident #3 to assist with the resident's meal. In addition, observation on 11/29/11, at 5:00 PM, revealed a CNA assisted Resident #3 with the meal while Resident #3 was seated at the dining room table in a wheelchair with the lap buddy in place.</p> <p>Interviews conducted on 11/30/11, at 2:30 PM, with CNA #7 (who worked the 3:00 PM-11:00 PM shift) and CNA #8 (who worked 7:00 AM-3:00 PM shift) revealed all residents who had restraints should have the restraint removed while at the dining room table; especially when staff was present with the residents. The CNAs stated Resident #3 required the assistance of staff for all meals and, since staff would be seated with the resident, staff should remove the resident's lap buddy during meals. CNA #8 acknowledged the lap buddy was not removed for the meals on</p>	F 221			

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F 221	Continued From page 5 11/29/11 for Resident #3. CNA #8 stated, "I just didn't remove the restraint." Interviews conducted on 11/30/11, at 2:40 PM, with LPN (Licensed Practical Nurse) #4 (who worked the 7:00 AM-3:00 PM shift on 11/30/11) and LPN #5 (who worked the 3:00 PM-11:00 PM shift on 11/30/11) revealed the LPNs monitored restraints for all residents to ensure the restraints were removed as ordered/planned, however, the LPNs were unaware the lap buddy utilized for Resident #3 was to be removed at meal times. Interview with LPN #6 (unit manager) on 11/30/11, at 2:40 PM, revealed the lap buddy should be removed for Resident #3 during meals. Interview with the Director of Nursing (DON) on 11/30/11, at 2:30 PM, revealed Resident #3's lap buddy should have been removed for meals when staff assisted the resident with meals and the resident was closely monitored.	F 221		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to provide care for each resident that promoted the resident's dignity and respect.	F 241		

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F 241	<p>Continued From page 6</p> <p>Observation of the morning meal on 11/29/11 revealed Certified Nursing Assistant (CNA) #10 stood at a resident's bedside while feeding the resident (unsampled Resident B).</p> <p>The findings include:</p> <p>Review of the facility's policy titled Activities of Daily Living/Feeding the Resident (dated 04/28/09) revealed residents that were unable to feed themselves would be assisted in a manner that provided nutrition, dignity, and social interaction and in a way that reduced the risk of aspiration. The policy directed staff to sit next to the resident and staff should not feed residents while standing. In addition, the policy indicated the resident should be able to see the staff member during the meal and that sitting eye-level with the resident prevents hyperextension of the resident's neck which could lead to choking.</p> <p>Observation on 11/29/11, at 7:45 AM, of the morning meal service revealed Certified Nurse Aide (CNA) #10 delivered a breakfast tray to unsampled Resident B. Further observation revealed CNA #10 stood at the resident's bedside while she fed the resident the meal. CNA #10 failed to sit at eye level of the resident while feeding the resident.</p> <p>Interview on 11/29/11, at 2:35 PM, with CNA #10 revealed she was knowledgeable of the requirement that staff should sit in a chair while feeding residents. CNA #10 stated there was not a chair in the room but she should have obtained a chair prior to feeding the resident.</p> <p>Interview with the DON on 12/01/11, at 9:30 AM,</p>	F 241			

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F 241	Continued From page 7 revealed staff should be seated in a chair beside the resident, and at the eye level of the resident, when assisting the resident with meals.	F 241			
F 253 SS=E	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 and interview, the facility failed to ensure housekeeping and maintenance services necessary to maintain a sanitary, comfortable, and orderly environment were provided. A card table used for resident dining had a hole in the top of the table and torn edges which created a surface that was not comfortable or sanitary for the residents. A "Lap Buddy" restraint used for Resident #3 had torn areas in the covering and was in disrepair. A toilet tissue dispenser was missing from the wall in resident room 221 which was not comfortable or orderly for the resident. The overbed table in one resident room was chipped and splintered around the edges which created a surface that was not comfortable for the resident. The findings include: An interview with the facility Administrator on 11/30/11, at 12:57 PM, revealed the facility did not have a written policy regarding maintenance of resident equipment and repairs. However,	F 253			

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F 253	<p>Continued From page 8</p> <p>according to the Administrator, the facility had developed a work order process to be completed by staff to identify items in need of repair.</p> <p>Observation on 11/29/11, at 7:06 AM, in the North Hall dining room revealed a resident was seated and served the breakfast meal at a card table. Additional observation revealed two holes in the top of the card table and the edges of the table were very worn and tattered which created a surface that would be difficult to ensure a sanitary and comfortable environment was maintained.</p> <p>Observations conducted during the initial tour on 11/29/11, at 7:20 AM, revealed an overbed table in room 120 that had chipped/splintered edges which created a surface that would also be difficult to ensure a sanitary and comfortable environment was maintained. In addition, a toilet tissue dispenser was missing from the wall in resident room 221.</p> <p>Observation of Resident #3 on 11/29/11, at 8:00 AM, revealed facility staff utilized a "Lap Buddy" restraint to ensure the resident's proper positioning when seated. The covering of the "Lap Buddy" had torn and rough edges.</p> <p>An interview conducted with the facility Maintenance Director on 12/01/11, at 10:15 AM, revealed staff was to complete a maintenance request form for items identified to be in need of repair, place the requests in a box at each nurses' station, and the Maintenance Director collected the requests daily. According to the Maintenance Director, the items identified were repaired immediately or as soon as parts or supplies were available. Further interview</p>	F 253			

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F 253	Continued From page 9 revealed the Maintenance Director was not aware the card table was being utilized for residents and was not aware of the chipped/splintered overbed table and missing toilet tissue dispenser. An interview conducted with the Occupational Therapist (OT) on 12/01/11, at 10:32 AM, revealed the therapist was responsible to report resident equipment that needed repair and was not aware that Resident #3 had a torn lap buddy. Further interview revealed resident equipment was inspected and replaced quarterly or if the resident had a therapy evaluation, and the equipment to be utilized for therapy was observed to be in need of repair. According to the therapist the card table was utilized for residents with low-rise wheelchairs for meals. The therapist was aware the table was in disrepair and was to be replaced.	F 253		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by:	F 328		

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F 328	<p>Continued From page 10</p> <p>Based on observations, interviews, record reviews, and review of facility policy/procedure, it was determined the facility failed to ensure one of nineteen sampled residents (Resident #9) and one unsampled resident (Resident B) received proper care and treatment related to oxygen administration and that unqualified staff did not administer oxygen therapy. Resident #9 and Resident A were observed on 11/29/11 to have a nasal cannula in place to receive oxygen; however, the oxygen container was not in operation.</p> <p>The findings include:</p> <p>A review of the facility policy/procedure Oxygen Administration (no effective date) revealed when administering oxygen to residents staff was required to turn the oxygen on and adjust the flow meter to the prescribed flow rate (1-6 liters/minute). The policy stated the primary staff person responsible would be a licensed nurse and the secondary responsible staff person would be a therapist. The facility Administer confirmed on 11/29/11, at 3:15 PM, this was the policy/procedure presently used in the facility.</p> <p>1. Review of the medical record of Resident #9 revealed the facility admitted the resident on 11/30/09 with diagnoses that included congestive heart failure and dementia. Review of the physician's orders for Resident #9 dated 07/14/11 revealed the resident was to receive oxygen at two liters per minute (2 L/min) via a nasal cannula. Review of the comprehensive care plan for Resident #9 dated 10/25/11 revealed the resident was to receive oxygen in accordance with physician's orders.</p>	F 328		

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F 328	<p>Continued From page 11</p> <p>Observations on 11/29/11, at 8:40 AM, revealed Resident #9 in a wheelchair in the hallway of the South Hall near the nursing station. The resident had a portable oxygen container hanging on the back of his/her wheelchair. The flow meter on the oxygen container was set on zero and was delivering no oxygen to the resident.</p> <p>Interview with the South Hall supervisor on 11/29/11, at 8:40 AM, revealed the resident's oxygen should have been turned on to 2 L/min. According to the supervisor, residents requiring oxygen therapy utilized portable canisters when up in a wheelchair. The supervisor stated staff was required to turn on the flow meter when the resident was placed into the chair and ensure the delivery rate was correct. The supervisor stated the facility State Registered Nursing Assistants (SRNA) were responsible for ensuring the flow meter was turned on and delivering the correct rate. Licensed staff was required to ensure the residents were receiving the physician ordered flow rate at least one time each shift.</p> <p>Interview on 11/30/11, at 10:10 AM, with SRNA #2 revealed staff was required to turn on the resident's oxygen when they were connected to the portable oxygen canister. According to SRNA #2, licensed nursing staff was required to check the setting during the day to ensure the resident was receiving the correct amount of oxygen. SRNA #2 stated the amount of oxygen each resident was to receive was documented on the SRNA care plan sheet at the nursing station.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 11/30/11, at 9:40 AM, revealed licensed staff</p>	F 328			

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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 12/01/2011
NAME OF PROVIDER OR SUPPLIER LIBERTY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 616 S WALLACE WILKINSON BLVD, PO BOX 1435 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 328	<p>Continued From page 12</p> <p>was required to monitor the resident's oxygen to determine if the oxygen was on, needed to be filled, and was at the right setting. According to LPN #1, licensed staff performed random checks each shift. LPN #1 stated the SRNAs were responsible for ensuring the oxygen was turned on for the resident. The LPN was unaware the facility policy/procedure required a licensed nurse to initiate the oxygen therapy.</p> <p>2. Review of the physician's orders for Resident A revealed the resident was to receive oxygen at 2 L/min via nasal cannula continuously due to congestive heart failure. Review of the SRNA care plan for Resident A revealed the resident was to receive oxygen per nasal cannula at 2 L/min.</p> <p>Observations on 11/29/11, at 3:35 PM, revealed Resident A in a wheelchair at the South Hall nursing station. The resident had a portable oxygen canister hanging from the back of the wheelchair. The oxygen flow meter was set to zero.</p> <p>Interview with SRNA #3 on 11/29/11, at 3:35 PM, revealed the SRNAs were required to ensure the oxygen was at the correct flow rate when the resident was placed into the chair. SRNA #3 confirmed the oxygen for Resident A was not turned on.</p> <p>Interview with SRNA #3 on 11/29/11, at 3:50 PM, revealed the resident was already in the chair when she arrived for work. SRNA #3 stated the SRNA care plan documents how much oxygen the resident was to receive. SRNA #3 also stated SRNAs were responsible for ensuring each</p>	F 328			

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F 328	Continued From page 13 resident's oxygen was turned on when they were placed into the chair. Interview with the Director of Nursing (DON) on 11/30/11, at 9:30 AM, revealed the SRNAs were responsible for ensuring the oxygen flow meter was turned on when they got the resident out of bed and used the portable oxygen canister. The DON stated licensed nursing staff was required to monitor the resident's oxygen therapy during rounds each shift. The DON was unaware the facility policy/procedure required licensed nurses and/or a therapist to initiate the resident's oxygen therapy.	F 328			
F 441 SS=D	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 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.	F 441			

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F 441	<p>Continued From page 14</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to provide a safe, sanitary environment to help prevent the development and transmission of disease and infections for residents during the delivery of breakfast trays on 11/29/11. Observation of the morning meal on 11/29/11 revealed a CNA failed to wash/sanitize hands between resident contact during the delivery of breakfast trays. Additionally, the facility failed to have an effective Infection Control Program as indicated by staff improperly placing a visibly soiled incontinence brief, soiled incontinence wipes, and soiled gloves on the floor beside a resident's bed.</p> <p>The findings include: A review of the facility Infection Control policy</p>	F 441		

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F 441	<p>Continued From page 15</p> <p>Hand Hygiene/Handwashing (dated 08/31/11) revealed handwashing was the single most important procedure for preventing the spread of infection. The policy directed staff to wash hands between resident contact. Review of the facility's policy titled Adult Brief or Underpad (dated 10/31/09) revealed adult briefs or underpads were disposable and should be folded so the fecal material was contained and should be discarded in the designated waste receptacle.</p> <p>1. Observation of the breakfast meal on 11/29/11 revealed CNA #9 delivered a tray to a resident in room 208. CNA #9 positioned the resident's bedside rolling table, opened the items on the tray for the resident, discarded an empty box in the trash, and exited the room and returned to the meal cart and continued to obtain and deliver resident trays. CNA #9 failed to wash/sanitize her hands after contact with potentially contaminated items.</p> <p>Further observation revealed CNA #9 delivered a tray to a resident seated in the common area. CNA #9 placed a cloth napkin on the resident's chest area to use as a clothing protector and then opened the items on the resident's tray. CNA #9 patted the resident on the arm, discarded plastic lids in a garbage receptacle, and then returned to the meal cart and continued to deliver resident trays.</p> <p>CNA #9 obtained a tray from the meal cart and placed it on a rolling table in the common area. CNA #9 positioned the table in front of a resident and placed a cloth napkin on the resident's chest area. CNA #9 removed the lids and plastic covering from the food and discarded the items in</p>	F 441		

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F 441	<p>Continued From page 16</p> <p>a garbage receptacle. Observation revealed CNA #9 failed to wash/sanitize her hands after resident contact.</p> <p>Interview on 11/29/11, at 2:30 PM, revealed CNA #9 was knowledgeable of the requirement to wash/sanitize hands after resident contact. CNA #9 stated she had failed to obtain hand sanitizer from the storage room when starting her shift. CNA #9 stated by not sanitizing/washing hands she could have spread germs from one resident to another.</p> <p>Interview on 12/01/11; at 9:30 AM, with the Director of Nursing (DON) revealed staff was required to wash/sanitize hands between resident contact or after contact with any contaminated surface.</p> <p>2. Observation during the initial tour on 11/29/11, at 8:25 AM, revealed CNA #1 was in the process of providing incontinence care to unsampled Resident C. Further observation revealed an incontinence brief and two disposable wipes visibly soiled with fecal material lying on the floor beside the resident's bed. Continued observation revealed CNA #1 removed her gloves and tossed the gloves over the resident's bed to the area where the soiled incontinence brief and wipes were on the floor.</p> <p>Interview with CNA #1 on 11/29/11, at 10:25 AM, revealed the CNA had forgotten to obtain a trash bag to contain the soiled items. CNA #1 confirmed it was the facility's policy to bag all soiled items in plastic bags to prevent the spread of germs and she had just failed to follow the policy. CNA #1 stated she should have obtained</p>	F 441		

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F 441	Continued From page 17 all items needed prior to starting the incontinence care. Interview on 11/29/11, at 10:45 PM, with the South Wing supervisor revealed staff should prepare all items prior to providing care to residents. The supervisor stated staff should never place soiled items on the floor. The supervisor acknowledged trash cans were in the resident rooms and could be used if staff failed to have a trash bag with them. The supervisor stated staff would be required to remove the bag from the resident's room after the incontinence care was completed.	F 441			

F-164 483.10(E), 483.75(I)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

Liberty Care Center will continue to extend the right of personal privacy and confidentiality to its residents.

1) LPN #4 was reeducated and given a written counseling regarding providing personal privacy to resident #6 (and all other residents) during skin assessments and other treatments and/or while providing care including ensuring privacy curtains and/or curtains or blinds on windows that have a view to the exterior of the facility are closed.

RN #1 was reeducated and given a written counseling regarding providing privacy to resident #10 (and all other residents) during skin assessments and other treatments and/or while providing care including ensuring privacy curtains are in place and closed.

2) All residents of Liberty Care Center have the potential to be affected by this practice.

3) Licensed staff and SRNA's were inserviced regarding providing privacy to all residents during assessments, treatments and/or while providing care, including ensuring privacy curtains are pulled and/or curtains or blinds that have a view to the outside are closed. This inservice was provided by Staff Development Coordinator on 12/9/11 and 12/28/11.

4) During daily rounds, Unit Managers will observe SRNA's and licensed staff while providing care and performing assessments and treatments to ensure privacy is observed. Any concerns identified will be addressed immediately.

DNS and/or Executive Director will observe care by licensed staff and SRNA's during their weekly rounds to ensure privacy is provided.

The result of these rounds will be reviewed by the IDT during the monthly Performance Improvement Committee meeting monthly for three months and quarterly thereafter.

4) Date of compliance: January 15, 2012

F-221 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS

Liberty Care Center will continue to ensure that each resident has the right to be free from any physical restraint imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

- 1) Resident #3 will have her "Lap Buddy" removed every two hours, at meal times and prn.

The care plan for resident #3 was updated on 12/5/11 to indicate that her "Lap Buddy" will be removed every two hours, at meal times and prn. The SRNA worksheet was updated on 12/5/11 to indicate that resident #3's "Lap Buddy" is to be removed every two hours, at meal times and prn.

- 2) All residents with restraints have the potential to be affected by this practice. A list of residents who have restraints was pulled from the RCS system. An audit was completed on 12/27/11 to ensure the care plan and SRNA worksheet of those residents with restraints indicate the placement of the restraint and instructions for the periodic release of the restraints. Updates were completed as needed. Liberty Care Center continues to review restraints and their release on an individual basis.

- 3) New restraint use will be assessed on an individual resident basis. An assessment will be done on admission, quarterly and on an "as needed" basis by the IDT. Restraint use will be care planned and placed on the SRNA worksheet at the time of implementation. Any current restraint in use will be reviewed quarterly and on an "as needed" basis by the IDT for reduction and to ensure the care plan and SRNA worksheet indicate current use and instructions for release.

SRNAs and licensed staff were inserviced by the Staff Development Coordinator on 12/9/11 and 12/28/11 regarding following the care plan and/or SRNA worksheets, including the use and releasing of restraints.

Random observations by the Unit Managers, Staff Development Coordinator, and DNS were done during the month of December to ensure SRNA worksheets are being used and followed for release of restraints.

- 4) Unit Managers will observe restraints on their units daily as a part of their daily rounds for proper use and release of the restraint. UM's will update SRNA worksheets weekly and prn with any new care plan changes, particularly with the use and/or release of restraints. Any concerns identified will be addressed immediately by the IDT.

Weekly rounds by the Executive Director and/or the DNS will include observations to ensure restraints are released per care plan and SRNA worksheet.

An audit will be completed monthly by the MDS Coordinator to ensure restraints are care planned and SRNA worksheets are updated to reflect any changes. This audit as well as the results from the ED/DNS rounds will be reported to the IDT during the monthly Performance Improvement Committee meeting, monthly for three months and quarterly thereafter.

- 5) Date of compliance: January 15, 2012

F-241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

Liberty Care Center will continue to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

- 1) SRNA #10 has been reeducated regarding the policy entitled "Activities of Daily Living/Feeding the Resident" and given a written counseling regarding the proper procedure for feeding residents at bedside. Resident B will be assisted out of bed for meals as her condition allows.
- 2) All residents who are unable to feed themselves or who need additional help with eating have the potential to be affected by this practice.
- 3) An inservice presented by the Staff Development Coordinator was held on 12/9/11 and 12/28/11 for licensed staff and SRNAs to review the aforementioned policy and the proper procedure for feeding residents at bedside.
Daily observations by Unit Managers and other licensed staff with administrative duties will be conducted to ensure residents are being fed in a dignified and respectful manner. Any concerns identified will be corrected immediately.
Weekly observation rounds will be made by the Executive Director and/or DNS to ensure residents are being fed in a dignified and respectful manner. Any concerns identified will be corrected immediately.
- 4) The result of these observations will be presented to the IDT by the DNS for review at the monthly Performance Improvement Committee meeting monthly for three months and quarterly thereafter.
- 5) Date of compliance: January 15, 2012

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

Liberty Care Center will continue to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.

- 1) The card table cited under this section was removed from use in the facility on 11/29/11 and replaced with a different table.
The overbed table in room 120 was removed from the resident room and replaced on 11/29/11.
The "Lap Buddy" of resident #3 was replaced on 11/29/11.
The toilet paper dispenser was replaced and affixed to the wall in the bathroom of room 221 on 11/29/11.
- 2) All residents who reside at Liberty Care Center have the potential to be affected by this practice.
- 3) In an inservice presented by the Staff Development Coordinator on 12/9/11 and 12/28/11, staff were reeducated regarding the procedure for reporting maintenance and equipment issues and the use of work orders to report these issues.
Daily rounds on their units by Unit Managers include looking at environmental issues and equipment repair needs. Weekly rounds are completed by the Executive Director and Maintenance both separately and together and are documented on a rounds sheet. Any problems identified will be addressed as soon as possible before the next week's rounds, with issues being prioritized according to need.
- 4) Round sheets will be presented by the Executive Director or Maintenance Director to the IDT at the monthly Performance Improvement Committee meeting for three months and quarterly thereafter.
- 5) Date of compliance: January 15, 2012.

F-338 483.25(K) TREATMENT/CARE FOR SPECIAL NEEDS

Liberty Care Center will continue to ensure that residents receive proper treatment and care for special services, including respiratory care.

1) Oxygen for Resident #9 and Resident B was immediately checked by licensed staff and administered at the ordered rate. Additionally, licensed staff assessed each resident's respiratory status, including monitoring oxygen saturation by pulse oximetry. All portable oxygen canisters were checked and labeled with the prescribed liters per minute as ordered.

2) All residents with orders for oxygen administration were identified as having the potential to be affected by this practice. All other residents with oxygen were reviewed by licensed staff to validate correct administration of oxygen.

3). SRNAs and licensed staff were inserviced on 12/9/11 and 12/28/11 by Staff Development Coordinator regarding the policy and procedure on providing oxygen to residents, including the change to facility protocol, including ensuring the nasal cannula is in place, portable oxygen tank contains enough oxygen and that the portable tank is turned on and to the proper setting.

A review of all oxygen orders was performed to ensure orders are correct and care plans and SRNA worksheets were updated and revised as needed.

When a portable oxygen tank is put into use, licensed staff will ensure it is stickered with the correct oxygen flow for that resident. Unit Managers will do a random spot-check daily to ensure oxygen is turned on and at the proper setting. Any concerns identified will be addressed immediately.

A facility protocol has been implemented that allows SRNAs to switch a resident from a concentrator to the portable liquid oxygen tank. Licensed staff will still be responsible for putting oxygen orders on the MAR, putting a sticker on the portable and concentrator indicating the ordered flow and placing this information on the SRNA worksheet. Licensed staff will monitor portable tanks 2 times per shift to ensure the tank is full.

In weekly rounds, the DNS will monitor oxygen administration on a random basis and note on a rounds sheet. Any concerns identified will be addressed immediately.

4) The DNS will track and trend any reported problems and all data will be reported monthly to the facility Performance Improvement Committee for three months and quarterly thereafter.

5) Date of Compliance: January 15, 2012.

F-441 INFECTION CONTROL, PREVENT SPREAD, LINENS

Liberty Care Center will continue to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

1) SRNA #9 was given a written counseling regarding following the infection control policy, particularly during meal service and between resident contact or contact with any contaminated surface.

SRNA #1 was given a written counseling regarding the infection control policy, particularly while giving incontinence care and in the disposal of soiled and/or contaminated items and the use of bags to contain these items. SRNA #1 removed the soiled items from the resident floor and cleaned the floor with bleach wipes.

2) All residents who live at Liberty Care Center have the potential to be affected by this practice.

3) Licensed staff and SRNA's were inserviced on 12/9/11 and 12/28/11 by the Staff Development Coordinator regarding following the infection control policy, particularly while giving incontinence care, the disposal of soiled and/or contaminated items and the use of bags to contain these items and handwashing and/or using antibacterial gel between resident contact during meal service and at other times of care.

Unit Managers will continue to make daily rounds to observe for infection control issues. Any concerns identified will be addressed immediately.

Executive Director and DNS will observe infection control practices as part of their weekly rounds. Any issues identified will be addressed immediately.

4) The result of these rounds will be presented to the IDT at the monthly Performance Improvement Committee meeting for review. Infection Control is a topic that is always on the agenda at the monthly PIC meeting.

5) Date of Compliance: January 15, 2012.

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NAME OF PROVIDER OR SUPPLIER LIBERTY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 616 S WALLACE WILKINSON BLVD, PO BOX 1435 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 11/29/11, 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			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.