STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366427	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Nursing Center of Colerain Inc	8440 Livingston Road Cincinnati, OH 45247

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 25908 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on review of the facility incident report, staff interviews and policy review, the facility failed to ensure staff appropriately disposed of an insulin needle after use. This had the potential to affect one (#70) out of three residents reviewed for infection control. The facility census was 61. Findings include: Review of the facility incident report dated 05/05/24 revealed while State tested Nursing Assistant (STNA) #44 was emptying the trash can in Resident #70 bathroom when she was stuck by a hypodermic insulin needle. The investigation noted the facility was unsure who threw the needle away or who the needle was used on prior to being disposed of in Resident #70's bathroom. Interview with the Director of Nursing (DON) on 07/08/24 at 2:00 P.M. revealed an investigation ensued and all staff were educated to prevent any further incidents following STNA #44's needle stick on 05/05/24. The DON confirmed Resident #70 does not have orders for insulin or injections so the needle in the bathroom trash can did not belong to this resident. The DON further noted the facility could not identify who put the needle in the trash can and could not identify which resident it was used for prior to it being placed in Resident #70's trash can. The DON confirmed needles are to be properly disposed of in sharps containers. Review of the Infection Control Policy undated for disposal of sharp materials revealed no sharps should be thrown in the trash. Sharps should not be capped and placed in the sharps containers. As a result of the incident, the facility took the following actions to correct the deficient practice by 05/12/24: On 05/05/24, the facility immediately began an investigation regarding the used needle found in Resident #70's room. On 05/05/24, all sharps containers were checked and replaced if needed by the DON and Infection Preventionist #14. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/05/24, the DON and Infection Preventionist #14 started all staff education regarding proper disposal of needles, sharps and hazardous waste. The education was completed on 05/12/24. On 05/05/24, DON and Infection Control Preventionist # 14 began trash monitoring which continued daily through 05/12/24 with no further incidents. Observations of nurses during medication passes on 07/01/24 and 07/08/24 revealed sharps containers on each medication cart. The sharps containers were not over flowing. Staff were observed appropriately disposing of needles in sharps containers. This deficiency represents non-compliance investigated under Complaint Number OH00154496.