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Division of Health Care
Southern Enforcement Branch

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

PRINTED: 12/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185274		C 11/29/2012

NAME OF PROVIDER OR SUPPLIER
WEST LIBERTY NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
774 LIBERTY ROAD
WEST LIBERTY, KY 41472

(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 A standard health survey was conducted on 11/27-29/12. Deficient practice was identified with the highest scope and severity at "D" level. An abbreviated standard survey (KY19394) was also conducted at this time. The complaint was substantiated with deficient practice identified.	F 000	To the best of my knowledge and belief, as an agent of West Liberty Nursing and Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the allege deficiencies. This plan of correction is prepared and /or executed solely because it is required by the provisions of Federal and State Law.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility policy review, and review of a facility investigation report, it was determined the facility failed to ensure the residents' environment remained as free from accident hazards as possible. On 10/12/12, at approximately 9:30 AM, staff discovered Resident #1 exited the facility. Interviews with staff revealed that the door alarm which had been installed on 10/11/12, had a volume which had been preset by the manufacturer and was not loud enough to be heard at the nurses' station. The facility notified the alarm company on 10/11/12, who increased the volume on the alarm on 10/12/12. The previous door alarm used by the facility was also	F 323	West Liberty Nursing and Rehabilitation Center strives to ensure the residents' environment remain as free from accident hazards as possible. Upon residents return to the facility, facility staff discovered that resident #1 did not have his Wander Guard bracelet in place. The bracelet was immediately replaced by a charge nurse. Nursing and administrative staff were posted at all exit doors as a precaution in order to ensure that no residents exited without supervision until door alarm sound was increased and a second alarm installed. They remained in place at all times until the exit alarm sound was increased and a second alarm was installed by the facility contractor for the code alert system on 10/12/12.	12/10/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pamela Jo Burton
TITLE: Administrator
(X6) DATE: 12-19-12

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 323	Continued From page 1 reconnected on 10/12/12. To disable this alarm, staff was required to manually turn off a switch at the nurses' station at the second alarm. However, the front door exit remained unsecured from 10/11/12 in the late evening until 10/12/12, at 10:00 AM. The findings include: An interview conducted with the Administrator on 11/27/12, at 11:55 AM, revealed the facility did not have a policy related to the checking of wander door alarm checking. A review of the medical record for Resident #1 revealed the resident was admitted by the facility on 10/11/12, at 4:30 PM, with diagnoses that included Alzheimer's, Diabetes Mellitus, Congestive Heart Failure, and Psychosis. A review of the Medication Administration Record (MAR) for Resident #1 revealed Licensed Practical Nurse (LPN) #3 had verified Resident #1 was wearing a Code Alert bracelet on 10/12/12, at 6:00 AM. Observation of Resident #1 on 11/27/12, at 2:40 PM, revealed Resident #1 was observed standing in the resident's bedroom doorway unassisted. The resident was observed to be wearing a Code Alert bracelet on the resident's right wrist. An interview conducted with State Registered Nursing Assistant (SRNA) #6 on 11/28/12, at 9:28 AM, revealed on 10/12/12, at approximately 9:30 AM, she heard the front lobby door alarming as she was coming out of a resident bedroom. The SRNA revealed the alarm was barely audible.	F 323	completed on 10/12/12, each door alarm was tested by the Maintenance Director and the Administrator to ensure that doors were sounding appropriately. Each resident with an order for a code alert was assessed by the DON on 10/12/12 to ensure that bracelets were in place, free of defects and functioning correctly. The MDSC completed a risk elopement assessment for each resident on 10-12-12 to ensure all residents at risk for elopement had been correctly identified. No other residents were identified to need a Wander Guard bracelet. An additional assessment was completed by the DON, Social Services Director or MDSC on 10-12-12 to identify any resident at high risk for removing bracelet and a second bracelet was temporarily placed until 10-15-12 when a stronger bracelet was obtained. On 10/15/12, nylon bracelets were obtained and each resident with an order for a code alert bracelet had these nylon bracelets applied by the charge nurse and an SRNA. All licensed nursing staff received education by DON, RN Supervisor, Administrator, MDSC, or Social Service Director regarding importance of identifying residents who are at high risk for removing code alert bracelets no later than 10/15/12.	

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F 323	Continued From page 2 The SRNA stated she checked the door, found it to be slightly ajar, and then immediately called to notify the nurse to begin a head count of all the residents in the facility. According to the SRNA, Resident #1 was discovered missing and a search for the resident was immediately initiated. The SRNA revealed Resident #1 was found and returned to the facility by staff uninjured. The SRNA stated she had not been told prior to Resident #1 exiting the building on 10/12/12, that the door alarm volume level was low and not loud enough to hear well. An interview conducted with the Maintenance Supervisor on 11/28/12, at 11:25 AM, revealed the Maintenance Supervisor had checked the front door alarm on 10/11/12, and was unsure of the time but stated it was in the late evening, after the alarm was installed by the alarm company. The Maintenance Supervisor stated he was aware the alarm volume was too low. The Maintenance Supervisor stated he had failed to secure the exit or inform administrative/nursing staff. The Maintenance Supervisor revealed the alarm had a volume which was preset by the manufacturer and was not loud enough to be heard at the nurses' station. The Maintenance Supervisor stated he had immediately notified the alarm company on 10/11/12, to increase the volume on the alarm and to reconnect the previous alarm which had been used by the facility. The Maintenance Supervisor stated any time an outside door was opened the alarm would sound, and would have to be manually turned off at the nurses' station. According to the Maintenance Supervisor, he was responsible for checking the door alarms every week to ensure they are functioning properly.	F 323	Additional education at that time included education related to elopement procedures, identifying residents at risk for elopement, where to find the notebook containing pictures of those residents at risk for wandering, and emergency procedures to follow in the case of a system malfunction regarding the alarm system, doors or code alert bracelets. Additional education was provided to all staff by the DON, MDSC, SS Director or the Administrator no later than December 31, 2012, regarding the importance of ensuring that the resident's environment remains as free from accidents and hazards as possible. The maintenance director received one-on-one education by the Administrator on 10/12/12 regarding the importance of alerting the Administrator immediately of any system malfunction regarding the Wander Guard System and initiating actions to protect the residents from potential harm during an outage in any part of the system. The DON or MDSC completed a Code Alert Device Assessment weekly for four weeks after the 10/12/12 incident on each resident that utilizes a code alert bracelet in order to ensure that any changes in behavior were captured and additional interventions were implemented immediately. The results of these reviews and audits were forwarded to the Weekly Focus	

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F 323	Continued From page 3 An interview with LPN #2 on 11/29/12, at 10:10 AM, revealed she had been working on 10/12/12, and had not been informed that the front door wander alarm had not been working properly. The LPN stated staff should have been posted at the door to prevent a wandering resident from exiting the facility. An interview conducted with LPN #1 on 11/28/12, at 5:30 PM, revealed she had worked the second shift on 10/11/12. The LPN stated she had not been notified by the Maintenance Supervisor that the front door wander alarm was not working properly. The LPN stated staff should have been stationed at the door if she had been notified that the volume was too low. An interview conducted with Registered Nurse (RN) #2 on 11/27/12, at 4:30 PM, revealed she was the Supervisor and was working on 10/11/12 and 10/12/12. The RN stated she had not been notified by the Maintenance Supervisor that the front door wander alarm was not working properly and the alarm volume was too low. RN #2 stated if she had known she would have placed a staff person at the door to prevent wandering residents from exiting the facility. An interview conducted with the alarm company representative on 11/28/12, at 11:40 AM, revealed he had been notified by the facility on 10/11/12, unsure of the time, regarding the low volume level of the front lobby alarm. The representative stated the alarm volume had been preset by the manufacturer. The representative stated his company had completed installation of the alarm on 10/11/12, and had returned to the facility to	F 323	Committee Meeting times four weeks for further monitoring and continued compliance. The Administrator or DON will also complete compliance rounds at least three times per week on various shifts, and weekly thereafter, to ensure that the resident's environment remains as free of accidents and hazards as possible. Any potential issue identified will be addressed immediately. These compliance rounds will be forwarded to the weekly focus meeting for four weeks. They will also be forwarded to the monthly Continuous Quality Improvement Committee meeting for further monitoring and continued compliance.	

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F 323	Continued From page 4 increase the volume on the new alarm on 10/12/12, after being notified by the facility, and also reconnected the previous alarm which had been used by the facility. An interview conducted with the Administrator on 11/29/12, at 11:55 AM, revealed she had not been notified by the Maintenance Supervisor on 10/11/12, after he discovered the front door alarm volume was not loud enough and stated she should have been. The Administrator stated staff should have been posted at the front lobby door until the alarm volume had been increased. The Administrator stated no previous problems had been identified from her review of the Maintenance Supervisor's door alarm checks.	F 323		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of facility guidelines, the facility failed to provide laboratory services for one of twelve sampled residents (Resident #4). Resident #4 had a physician's order for a Thyroid Stimulating Hormone (TSH) Level to be obtained annually in October. However, a review of documentation conducted on 11/28/12, revealed the laboratory test had not been obtained in October 2012. The findings include:	F 502	West Liberty Nursing and Rehabilitation Center strives to provide laboratory services to meet the needs of its residents. The TSH level on resident #4 was obtained on 12-5-12 by the Prolab Tech after several attempts with refusal by resident and reviewed. The Medical Director was notified by the LPN of the results and no further orders were received. An audit will be completed on 12-18-12 by the RN Supervisor of all residents' charts to determine that all current labs have been obtained. Any lab omissions found will be notified to the MD by the RN Supervisor for further orders.	12/10/2012

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F 502	Continued From page 5 Review of the facility policy/procedure for Laboratory Services (dated 08/01/12) revealed the facility would provide or obtain laboratory services to meet the needs of the residents. The policy also noted the licensed nurse was responsible to obtain a lab test when the physician ordered the lab test to be conducted. A review of the medical record revealed the facility admitted Resident #4 on 04/09/09, with diagnoses of Diabetes Insipidus, Congestive Heart Failure, Anemia, Esophageal Reflux, and Depression. Review of the current physician's orders revealed a Thyroid Stimulating Hormone (TSH) level was to be obtained annually in October. A review of the laboratory tests revealed a TSH level was obtained on 10/17/11, and the level was 0.29 L (normal range 0.34-4.82 mIU/mL). However, there was no evidence the facility obtained a TSH level annually in October 2012 as ordered by the physician. Interview conducted with Registered Nurse (RN) #1 on 11/29/12, at 11:00 AM, revealed physician's orders for laboratory services were entered by the staff nurse into the computer to indicate when the laboratory collection was due to be done. The RN stated the laboratory company reviewed the data entered into the computer and obtained the laboratory specimens as ordered. RN #1 also stated a list of the laboratory tests obtained was provided to the nurses after the laboratory specimens had been collected. RN #1 stated the routine laboratory tests were also placed on the desk calendar for the nurses to review to ensure the laboratory specimens were obtained as	F 502	A review of the process used for obtaining labs was conducted by the DON on 12-3-12 and no changes to the current process were made. Licensed nursing personnel have received additional education by the RN Supervisor on 12-16-12 regarding proper input of labs in the computer. The RN Supervisor will monitor all new admits and readmits to ensure all lab orders are correct in the computer and all labs are obtained as ordered times four weeks. The results of these audits will be forwarded to the Continuous Quality Improvement (CQI) Committee for further monitoring and continued compliance.	

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F 502	Continued From page 6 ordered by the physician. RN #1 reviewed the computerized entries to ensure Resident #4's physician's orders for the laboratory tests had been entered and revealed the date for the TSH level to be obtained for Resident #4 had been entered as March 2012 instead of October 2012. RN #1 stated she had entered the wrong date when the laboratory tests were to be obtained into the computer system. The RN acknowledged the TSH level should have been done in October 2012. Interview with the Director of Nursing (DON) on 11/29/12, at 3:35 PM, verified staff nurses entered the laboratory information into the computer system and the lab company performed the tests based on that information. The DON stated the information for Resident #4 had been entered incorrectly and the TSH level had not been conducted as ordered by the physician.	F 502		

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1965, 1993 Survey under: NFPA 101 (2000 Edition), Chapter 19 (existing health care) Facility type: SNF/NF Smoke Compartment: 4 Fire Alarm: Complete fire alarm with smoke detectors Sprinkler System: Complete automatic sprinkler system Generator: Type II, Diesel installed 1993 A standard Life Safety Code survey was conducted on 11/28/12. West Liberty Nursing and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (life Safety from Fire) with the highest scope and severity at "D" level.	K 000	To the best of my knowledge and belief, as an agent of West Liberty Nursing and Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the allege deficiencies. This plan of correction is prepared and /or executed solely because it is required by the provisions of Federal and State Law.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as	K 018	West Liberty Nursing and Rehabilitation Center strives to ensure that all corridor doors resist the passage of smoke compartment, for residents, staff, and visitors.	1/10/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pamela J. Beuter
TITLE: Administrator
(X6) DATE: 12-19-12

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K 018	Continued From page 1 those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors would resist the passage of smoke. The deficiency had the potential to affect one smoke compartment, four residents, staff, and visitors. The findings include: Observation on 11/28/12, at 11:00 AM, revealed resident room doors 51, 47, 21, and 26 would not latch when shut. Resident room doors must latch to resist the passage of smoke. The observation was confirmed with the Regional Maintenance Director. Interview on 11/28/12, at 11:00 AM, with the	K 018	On 12-10-12, the Regional Maintenance Director ordered new doors for rooms 51, 47, 21, and 26. On 11-28-12 Maintenance checked all other doors to assure doors latch properly when shut. New doors will be installed by maintenance no later than 1-10-12. Maintenance/Housekeeping will monitor all doors weekly times four weeks to assure all doors latch properly. The results of the monitoring will be forwarded to the monthly Continuous Quality Improvement Committee (CQI) for further monitoring and continued compliance.	

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K 018	Continued From page 2 Regional Maintenance Director, revealed he was not aware the resident room doors, located in the corridor, would not latch. Reference: NFPA 101 (2000 Edition). 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide	K 045	West Liberty Nursing and Rehabilitation Center strives to ensure that illumination of the means of egress at the exit discharges according to National Fire Protection Association (NFPA) standards. On 12-12-12 an exit discharge for the lobby was purchased and installed by the Regional Maintenance Director with multiples bulb fixtures.	12/12/2012

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185274	A. BUILDING 01 - BUILDING B. WING	11/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST LIBERTY NURSING & REHABILITATION CENTER	774 LIBERTY ROAD WEST LIBERTY, KY 41472

(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
K 045	Continued From page 3 illumination of the means of egress at the exit discharges according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one smoke compartment, eight residents, staff, and visitors. The findings Include: Observation on 11/28/12, at 11:30 AM, revealed the exit discharge at the lobby had a single fixture with one bulb installed at the corridor emergency exit discharge. This arrangement would leave the exit discharge areas in darkness upon failure of any single fixture bulb. The observation was confirmed with the Regional Maintenance Director. Interview on 11/28/12, at 11:30 AM, with the Regional Maintenance Director, revealed he had not noticed the light fixture contained a single bulb. Reference: NFPA 101 (2000 Edition). 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045	Regional Maintenance Director checked all other exits on 11-28-12 for prober illumination egress fixture of more than one bulb lighting and found all others to have more than single lighting bulb fixtures. Maintenance or Housekeeping Supervisor will audit exit lighting weekly for proper illumination. These audits will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.	

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