



PRINTED: 01/10/2012  
FORM APPROVED  
OMB/NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186274	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED  12/21/2011
NAME OF PROVIDER OR SUPPLIER  WEST LIBERTY NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 774 LIBERTY ROAD, P O BOX 218 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	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.	
F 253 SS=D	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, interview, and review of the facility policy, it was determined the facility failed to ensure effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Observations throughout the facility revealed the women's shower room had a broken baseboard tile, a black "mold like" substance on the tile grout, and a rusty/stained shower chair available for use.  The findings include:  A review of the facility policy for Repair Requisitions (dated 01/01/95) revealed requisition forms were to be utilized for needed repairs identified by staff, residents, and visitors.  Observations of the women's shower room on 12/20/11, at 9:00 AM, revealed a broken baseboard tile that had sharp edges, a black "mold like" substance on the grout of the tile in	F 253	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 alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.  West Liberty Nursing and Rehabilitation strives to provide housekeeping and maintenance services necessary to maintain a sanitary and comfortable interior  On 12/20/11 maintenance replaced the broken baseboard tile in the women's shower room. Maintenance checked all other shower rooms on 12/20/11 to ensure that no other areas of tile needed to be replaced at that time.  On 12/22/11, housekeeping scrubbed the shower stall removing mold like substance on the grout of the tile. Any area that could not be cleaned was re-grouted by the Maintenance Supervisor by 1/3/12.	02/01/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Samela J. Burt* TITLE: Administrator (X6) DATE: 01/18/12

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 253	Continued From page 1 the shower area, and a shower chair with brown stains on the seat and rusty wheels that left rust stains on the tiles beneath the chair.  An interview with Housekeeper (HK) #1 on 12/20/11, at 9:30 AM, revealed the shower chairs were deep cleaned every week. HK #1 was aware of the shower chair with the rusty wheels and stained seat but stated the chair would not come clean. HK #1 was aware of the black "mold like" substance on the tile grout and stated it was hard to get clean. HK #1 was unaware of the broken baseboard tile in the women's shower room. HK #1 stated a requisition form was utilized to turn in the needed repairs.  An interview conducted with the Maintenance Director on 12/20/11, at 10:00 AM, revealed staff was to complete work orders when anything was in need of repair. According to the Maintenance Director, repairs that affect residents and their safety were completed before other repairs. The Maintenance Director was also unaware of the broken baseboard tile in the women's shower room.	F 253	shower areas had mold in the grout. All shower chairs were checked by the Housekeeping Supervisor on 12/22/11. Two replacement shower chairs were ordered by the administrator on 12/23/11 and received and put into use on 1/9/12. The two shower chairs with rusty wheels were taken out of circulation on 1/9/12.  The administrator provided education to the Maintenance Supervisor and Housekeeping Supervisor on 1/16/12 regarding the importance of daily compliance rounds and scheduled Housekeeping and Environmental Audits.  All staff received education by 1/23/12 by the Administrator regarding the proper utilization of maintenance requisition slips.  A Housekeeping Audit was completed on 1/4/12 and an Environmental audit was completed on 1/13/12, both by the Housekeeping Supervisor. Any areas of concern were noted and corrected at the time.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility policy, it was determined the facility failed to ensure services provided met professional standards of care. The facility failed	F 281	These environmental and housekeeping audits will be conducted weekly for four weeks, and quarterly thereafter, by the Housekeeping Supervisor and Maintenance Director. The results of these audits will be forwarded to the monthly Continuous Quality Improvement Committee (CQI) committee for further monitoring and continued compliance.		

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F 281	<p>Continued From page 2</p> <p>to ensure physician's orders were followed for one of twelve sampled residents (Resident #7). The facility failed to follow Resident #7's physician's orders to repeat a chest x-ray after the resident had completed ten days of antibiotics on 10/19/11.</p> <p>The findings include:</p> <p>A review of the facility policy for physician orders (dated 12/01/10) revealed the nurse who received an order was to acknowledge the order by their signature and a date. In addition, the nurse that received the order was to ensure the order was followed through.</p> <p>A review of Resident #7's medical record revealed diagnoses that included Reflux Esophagitis, Diabetes, and Right Lower Lobe Infiltrate. On 10/19/11, the physician of Resident #7 prescribed 100 mg (milligrams) of Doxycycline (an antibiotic) to be administered to the resident twice a day, for ten days, due to the resident's cough and congestion. Based on documentation, after completion of the antibiotic, a repeat chest x-ray was to be obtained. Further review of the medical record revealed no evidence a repeat chest x-ray had been obtained for Resident #7 ten days after the antibiotic was completed.</p> <p>An interview with the Director of Nursing (DON) on 12/20/11, at 2:00 PM, revealed when a nurse received the results of a laboratory study or an x-ray they were to notify the resident's physician of the results and document any additional orders for laboratory studies or x-rays. The DON verified the mobile radiology service had not been notified that a repeat chest x-ray for Resident #7 was to</p>	F 281	<p>West Liberty Nursing and Rehabilitation strives to meet/exceed professional standards of quality of care.</p> <p>Resident # 7 was assessed on 12/20/11 by the LPN charge nurse. The assessment revealed lungs clear to auscultation, no complaints of cough or congestion. The MD was notified on 12/20/11 by the charge nurse that repeat chest x-ray ordered for 10/29/11 was omitted. The charge nurse received and noted a new order for a repeat chest x-ray on 12/20/11. The chest x-ray was obtained on by the Mobile X-ray unit on 12/21/11. The results revealed normal chest examination with no tuberculosis and improved findings from 10/1/11. The MD was notified by the charge nurse on 12/21/11 of these results. No new orders were received.</p> <p>The procedure for obtaining x-rays was reviewed by the DON on 1/4/12. A new procedure regarding the tracking system for ensuring that x-rays are completed and results are received in a timely manner was implemented by the facility on 1/1/12.</p> <p>The nurse that noted the 10/29/11 order received individual education by the DON on 12/20/11 regarding the importance of following physician orders according to facility protocols and Standards of Practice.</p>	02/01/12	

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F 281	Continued From page 3 be obtained. The DON reportedly did not know why the chest x-ray had not been obtained for Resident #7 after the resident had completed the ten days of antibiotics.	F 281	All nursing staff received education by the DON on 1/10/12 regarding the importance of following physician orders per Standards of Practice and protocols for the new tracking procedure to be utilized for ensuring that x-rays are ordered and received in a timely manner.		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on observations, interview, facility policy, and record reviews, it was determined the facility failed to provide appropriate treatment and services to prevent urinary tract infections for two residents (Residents #2 and #5) in the selected sample of twelve residents. Observations during the provision of indwelling catheter care for Residents #2 and #5 revealed Certified Nurse Aide (CNA) #1 failed to follow facility policy and cleansed the perineal area in upward strokes and cleansed the indwelling catheter tubing toward the insertion site of the resident's indwelling urinary catheter.  The findings include:  A review of the facility's policy/procedure,	F 315	An audit of all physician orders for the last 30 days was completed on 12/30/11 and 12/31/11 by the RN Supervisor to ensure that all MD orders were implemented as directed by the physician and Standards of Practice.  The DON or RN Supervisor will review at least five charts per week for four weeks to ensure that orders are noted per facility protocol and that any follow up is completed as directed per Standards of Practice.  The results of these audits will be forwarded to the monthly CQI Committee for further monitoring and continued compliance.  West Liberty Nursing and Rehabilitation strives to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the clinical condition demonstrates that it is necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	02/01/12	

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F 315	<p>Continued From page 4</p> <p>Catheters/Urinary/Catheter Care-Female (dated 11/01/11) revealed staff was to use their nondominant hand to expose the urinary catheter insertion site and to use their dominate hand to cleanse the area around the catheter site in a circular motion. In addition, staff was to cleanse the catheter tubing by cleansing from the insertion site out to at least four inches. The policy further directed staff to turn the wash cloth and to wipe in a downward motion on one side of the area near the insertion site and then to wipe in a downward motion on the other side.</p> <p>1. Observation on 12/20/11, at 9:55 AM, of incontinence care for Resident #2 revealed CNA #1 failed to use a downward motion when she cleansed the area near the insertion site of the urinary catheter and failed to move away from the insertion site when she cleansed the catheter tubing. The CNA used upward strokes on the sides of the catheter insertion site and moved toward the insertion site when she cleansed the catheter tubing.</p> <p>2. Observation on 12/20/11, at 10:15 AM, revealed CNA #1 prepared items to provide catheter care for Resident #5. CNA #1 cleansed the sides of the catheter site with upward strokes and then cleansed the catheter tubing toward, not away from, the catheter insertion site.</p> <p>An interview on 12/21/11, at 11:45 AM, with CNA #1 revealed she realized she had failed to use appropriate technique when she provided catheter care to Resident #2 and Resident #5. CNA #1 stated she failed to wipe in downward motions and failed to cleanse the catheter away from the resident as trained. CNA #1 stated she</p>	F 315	<p>Resident #2 and resident #5 received appropriate catheter care by an RN supervisor on 12/21/11. The RN Supervisor conducted an assessment on 12/21/11 to ensure that resident #2 and #5 did not have any signs or symptoms of a urinary related infection. Additional follow-up assessment was completed on 1/18/12 by the DON to ensure that resident #2 and #5 had no signs and symptoms of a urinary related infection.</p> <p>On 1/10/12, the DON reviewed the infection control log for the last 90 days. No trends were identified related to inappropriate catheter care.</p> <p>The DON and RN Supervisor provided all nursing staff with one on one education regarding the facility policy related to appropriate peri care and catheter care and the importance of preventing urinary tract infections by utilizing protocols as directed by facility policy. Additionally, each SRNA was required to provide return demonstration to the DON or RN Supervisor regarding appropriate peri care and cath care. All education and return demonstrations will be completed by 1/30/12.</p> <p>The DON or RN Supervisor will monitor at least five episodes of catheter care each week for four weeks. All shifts will be included in the monitoring. Thereafter, the DON or RN Supervisor will monitor at</p>	

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F 315	Continued From page 5 was nervous during the procedure and failed to provide the catheter care correctly.  Interview on 12/20/11, at 2:30 PM, with the Director of Nursing (DON) revealed staff was expected to provide catheter care as outlined in the facility policy. The DON stated staff should always cleanse the perineal area with downward strokes and cleanse the catheter tubing by cleansing away from the resident.	F 315	least five episodes of catheter care per month to ensure that appropriate techniques are utilized. Any problems identified will be corrected at the time with appropriate education.  The results of these observations will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431	West Liberty Nursing and Rehabilitation Center strives to ensure that drug records are maintained appropriately and that all drugs and biologicals are labeled/stored/discarded appropriately.  The IV solution was removed from crash cart and a new bag replaced on 12/20/11 by the RN Supervisor.  The pharmacist conducted a complete audit of all medications and biologicals on the medication cart and the medication room on 12/20/11 to ensure that no outdated items were available for resident use. No outdated items were found.  The outdated IV solution was immediately removed from the Emergency Cart. No other biologicals or medications were found to be outdated during audits conducted on 12/20/11. No residents were affected by the practice.	02/01/12	

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F 431	Continued From page 6 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of facility logs, and review of manufacturer's labeling, it was determined the facility failed to ensure expired intravenous solutions were not available for resident use. A 1,000 milliliter (ml) bag of 5% Dextrose and 0.9% normal saline on the facility's emergency cart had exceeded the manufacturer's recommended expiration date and was expired.  The findings include:  Review of the facility policy/procedure Emergency Cart (dated effective 05/13/11) revealed a licensed nurse would review the cart daily to ensure that all items were present and in working condition.  Observation on 12/20/11, at 9:20 AM, of the facility's emergency cart revealed a 1,000 ml container of 5% Dextrose and 0.9% normal saline on the top of the cart available for resident use. The manufacturer's label on the container had an expiration date of July 2011, five months prior to the date of the observation.  Review of the log maintained by the facility of	F 431	On 1/11/12, the DON implemented a new assignment sheet for licensed nursing staff to utilize for auditing various areas of the facility where biologicals and medications are stored to ensure that biologicals and medications are discarded prior to expiration date.  The DON provided all nursing staff with additional education by 1/10/12 regarding the updated assignment sheet and the importance of ensuring that biologicals and medications are removed from circulation when the item becomes outdated. She also stressed the importance of checking the expiration date on all items during the crash cart checks.  The medication room, med carts and crash carts will be audited weekly for four weeks by DON or RN Supervisor and monthly thereafter. Additionally, the pharmacy tech will monitor the medication cart and medication room monthly to ensure that medications and biologicals are discarded prior to expiration date.  The results of these audits will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.		

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F 431	Continued From page 7 daily checks of the emergency cart revealed staff had documented that the cart contained no expired medications.  Interview on 12/20/11, at 9:20 AM, with LPN #1 revealed she had been responsible to check medications on the emergency cart on the days she had worked for the previous five months. According to LPN #1, she was unaware the IV solution had expired. LPN #1 stated she thought everyone looked at the expiration dates.	F 431			
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. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	West Liberty Nursing and Rehabilitation Center strives to 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.  Residents # 2, #4, and #6 were assessed by RN Supervisor on 12/21/11 revealing no signs or symptoms of infection present. A follow up assessment was completed by the DON 1/18/12 for resident #2 and #6 to ensure that no signs or symptoms of infection were noted for these residents. Resident #4 was discharged home 12/23/11.  The DON reviewed the Infection Control Log for the last 90 days on 1/10/12 to ensure that no trends were noted in relation to improper infection control techniques.  The DON provided additional education to all staff by 1/30/12 regarding the	02/01/12	

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F 441	<p>Continued From page 8</p> <p>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, record review, and facility policies, it was determined the facility failed to ensure an effective infection control program was maintained in an effort to provide a safe, sanitary, and comfortable environment for three of twelve residents (Residents #4, #6, and #2) and to help prevent the development and transmission of diseases and infection. One staff member, CNA #3, failed to wash/sanitize her hands after glove changes when providing care to Resident #4 and Resident #6. Additionally, staff failed to change gloves when going from a dirty area to a clean area while providing care to Resident #2.</p> <p>The findings include:</p> <p>Review of the facility policy/procedure, Personal Protective Equipment - Gloves (dated as revised August 2009) revealed staff was required to wash their hands after removing gloves.</p>	F 441	<p>importance of establishing and maintaining an infection control program that prevents the development and transmission of disease and infection. Isolation, hand washing protocols, gloving protocols and linen handling will be included in this education.</p> <p>The DON or RN Supervisor will observe at least five employees per week on different shifts to ensure that infection control practices are acceptable and that hand washing, gloving and linen handling protocols are implemented per facility policy. Thereafter, the DON, RN Supervisor or Charge Nurse will complete at least three audits per month (at least one on each shift) to ensure that appropriate infection control techniques are followed per facility protocols. Any violation of infection control procedures will be immediately corrected via education.</p> <p>The results of these audits will be forwarded to the monthly CQI Committee meeting for additional review and continued compliance.</p>	

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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	
F 441	<p>Continued From page 9</p> <p>1. Observations on 12/20/11, at 9:00 AM, revealed Certified Nursing Assistant (CNA) #3 provided incontinence care to Resident #6 while wearing gloves. CNA #3 removed her gloves, placed them and used supplies into the trash receptacles, moved the trash and linen receptacles into the storage room in the hallway, returned to the resident room, and donned new gloves. CNA #3 did not wash/sanitize her hands after glove removal. CNA #3 proceeded to provide Resident #4 assistance with dressing and, after the resident was dressed, the CNA removed her gloves, placed the resident's nightclothes into a plastic bag, and exited the room. CNA #3 placed the plastic bag into the linen receptacle in the hallway and proceeded down the hall. The CNA did not wash/sanitize her hands before she entered the next resident room.</p> <p>Interview with CNA #3 on 12/20/11, at 9:10 AM, revealed staff was required to wash/sanitize their hands between glove changes. CNA #3 confirmed she had not washed/sanitized her hands after glove removal because she had forgotten.</p> <p>2. Review of the facility policy entitled Personal Protective Equipment-Gloves (dated August 2009) revealed the policy failed to direct staff when to change gloves in the provision of care to a resident when they provided multiple procedures on the same resident. According to the Lippincott Manual of Nursing Practice, Ninth Edition, and utilized by the facility, revealed the standards of nursing practice required staff to change gloves between procedures on the same patient.</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  12/21/2011
NAME OF PROVIDER OR SUPPLIER  WEST LIBERTY NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 774 LIBERTY ROAD, P O BOX 219 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 441	<p>Continued From page 10</p> <p>Observation on 12/20/11 at 9:55 AM, revealed CNA #1 provided catheter care for Resident #2. CNA #1 failed to remove her soiled gloves after completion of the catheter care and before she removed the nasal oxygen tubing from the resident's nostrils. In addition, CNA #1 was observed to lift Resident #2's head to remove the resident's soiled gown and applied a clean gown while she continued to wear the soiled gloves. Further observation revealed CNA #1 continued to wear the soiled gloves to reapply Resident #2's nasal oxygen, to place a neck pillow under Resident #2's head/neck, and to touch the resident's face, hands, sheet, and call light.</p> <p>Interview with CNA #1 on 12/21/11, at 11:45 AM, revealed gloves were to be changed between residents when soiled or if going from a dirty area to a clean area. CNA #1 stated she failed to change gloves after providing catheter care for Resident #2. CNA #1 stated she was nervous during the procedure and just forgot to change her gloves.</p> <p>Interview on 12/21/11, at 2:30 PM, with the DON revealed staff was required to change gloves any time they provided care from a dirty area to a clean area. The DON confirmed CNA #1 should have changed gloves after the catheter care was completed and prior to the provision of other care for Resident #2.</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185274</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - BUILDING</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/21/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEST LIBERTY NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>774 LIBERTY ROAD, P O BOX 219 WEST LIBERTY, KY 41472</b>		
(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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Plan Approval: 1965, 1993</p> <p>Survey under: NFPA 101 (2000 Edition), Chapter 19 (existing health care)</p> <p>Facility type: SNF/NF</p> <p>Smoke Compartment: 4</p> <p>Fire Alarm: Complete fire alarm with smoke detectors</p> <p>Sprinkler System: Complete automatic sprinkler system</p> <p>Generator: Type II, Diesel installed 1993</p> <p>A standard Life Safety Code survey was conducted on 12/21/11. West Liberty Nursing and Rehabilitation Center was found to be in compliance with the requirements for participation in Medicare and Medicaid.</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.