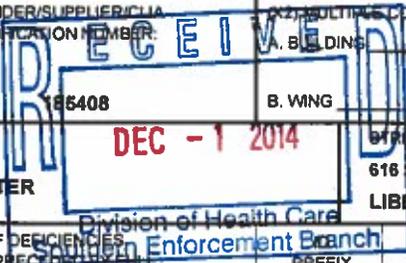


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/07/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LIBERTY CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539
--	--



(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	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 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior were provided in two (2) of fifty-two (52) resident rooms. Observations on 11/06/14 of resident room 121 revealed food particles and debris on the floor, black spots and dust on the windowsill, a white substance on Resident A's bedside table, and multiple dead ants beside the sink. In addition, observation in resident room 115 revealed a nightstand with broken wood and sharp edges, a loose and leaky sink faucet, and red stains on the wall above and below the light above the bed.</p> <p>The findings include:  Review of a policy titled "Cleaning and Disinfecting Residents' Rooms," revised August 2012, revealed all housekeeping surfaces would be cleaned daily and when surfaces were visibly soiled.</p>	F 253	<p>Liberty Care and Rehabilitation Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or other legal proceedings. This allegation of compliance is not intended to and does not establish any standard of care, contract obligation, or position, and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this allegation of compliance should be considered or relied upon as a waiver of any potentially applicable Peer Review, Quality Assurance, self critical examination, or any other legal privilege which the Facility may have. The Facility does not waive and specifically reserves the right to assert these privileges in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance, and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p> <p>1. Resident rooms 115 and 121 were cleaned by the housekeeping supervisor on 11/6/2014, including sweeping/mopping the floors, removal of any debris from the floor, cleaning the windowsill, and cleaning the bedside and over bed tables. The walls, sink area and other areas of the rooms were also cleaned including the wall above and below the light above the bed in room 115. On 11/6/2014 the Plant Operations Director removed a nightstand from room 115 and replaced it with an undamaged nightstand. He repaired a loose and leaky sink faucet and replaced the corner guard by the sink that had dead ants behind it. on 11/6/14 the Plant Operations Director and Administrator completed a review of rooms 115 and 121 to ensure there were no further housekeeping or maintenance issues that needed to be addressed.</p>	12/2/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>William Good</i>	TITLE Administrator	(X6) DATE 12/1/2014
--	------------------------	------------------------

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.

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

PRINTED: 11/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/07/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIBERTY CARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539</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	
F 253	<p>Continued From page 1</p> <p>Observation on 11/06/14 at 10:00 AM revealed there were two gloves on the B bed bedside table, and on the floor were one glove, dirty tissues, a used, dirty cup, and multiple areas of orange, brown, and black food particles. In addition, the windowsill was dusty with black spots. There was also a white substance on the A bed bedside table. Further observation revealed there were dead ants on the corner guard beside the sink.</p> <p>Observation on 11/06/14 at 10:10 AM of resident room 115 revealed the A bed nightstand trim had broken wood with a cracked corner guard leaving sharp edges. Further observation revealed the faucet was loose and leaking and there were red stains on the wall below and above the B bed light.</p> <p>Interview conducted with the Housekeeping Supervisor on 11/07/14 at 6:51 PM revealed she made rounds daily throughout the facility to identify housekeeping concerns and the last round she made was on Wednesday, 11/05/14. The Housekeeping Supervisor stated she had not identified any housekeeping concerns that needed attention at that time.</p> <p>Interview conducted with the Administrator on 11/07/14 at 6:58 PM revealed he was not aware of any housekeeping/maintenance concerns in resident rooms 115 and 121. The Administrator stated he performed daily rounds of the facility and had not identified any concerns. He stated Maintenance, Housekeeping, and Unit Managers also perform rounds daily and had not identified any concerns.</p>	F 253	<p>F253 Correction Continued:</p> <p>2. On 11/6/2014 the Administrator, Housekeeping Supervisor, and Plant Operations Director completed a round of the building completing an audit observing for other resident rooms or areas of the facility to ensure adequate housekeeping and maintenance services were being provided to maintain a sanitary, orderly, and comfortable interior. Any issues identified during the rounds were noted and corrected on 11/6/2014.</p> <p>3. On 11/7/2014 the Administrator educated the Housekeeping Supervisor and the Plant Operations Director on their responsibilities to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The Unit Managers were also educated on 11/7/2014 by the Administrator that they were responsible for completing routine rounds of their units to ensure they were clean and in good repair.</p> <p>Effective 11/23/14 the Administrator and Plant Operations Director will complete at least 3 weekly rounds of the facility per week for 4 weeks, then 2 weekly rounds of the facility per week for 4 weeks then at least 1 weekly round per week for 4 weeks to ensure the facility is clean and in good repair and that adequate housekeeping and maintenance services are being provided to ensure adequate housekeeping and maintenance services are being provided to maintain a sanitary, orderly, and comfortable interior. These rounds will be documented on an environmental rounds form.</p> <p>The Staff Development Coordinator, Unit Managers, and Director of Nursing will provide education to all staff regarding expectations for sanitary conditions of resident rooms, and expectations for work orders to be completed for any items needing repair. The education will include the requirement that any staff member observing a resident room or area that needs cleaning is responsible to either clean the area or to obtain the service through housekeeping staff. This education will be completed by 12/2/14.</p> <p>Effective 11/7/2014 Facility management members including the SSD, DON, Admissions Coordinator, Human Resources Director, Chaplain, MDS Coordinators, Weekend Supervisor and others will conduct routine environmental rounds to ensure the facility is clean and in good repair. Any identified issues will be immediately addressed and a report will be provided to the administrator.</p> <p>Effective 12/2/2014 all housekeeping staff and the housekeeping director will be trained by the administrator to use a daily cleaning list and a "deep clean" list while providing housekeeping services. This form will serve as a reminder of all the areas that need to be cleaned.</p>		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282			

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

PRINTED: 11/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/07/2014
NAME OF PROVIDER OR SUPPLIER  LIBERTY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282 SS=D	<p>Continued From page 2</p> <p><b>PERSONS/PER CARE PLAN</b></p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure the plan of care was implemented for one (1) of twenty (20) residents (Resident #9). Resident #9's care plan, developed by the facility, required staff to ensure the resident was wearing TED hose (specialized hosiery designed to help prevent the occurrence of and guard against further progression of disorders of the veins such as swelling and blood clots) and that there was an alarm on the resident's chair. However, observations on 11/05/14 and 11/06/14 revealed the resident was not wearing TED hose and was not utilizing a chair alarm.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Care Plans - Comprehensive," (revision date October 2010) revealed an individual, comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs would be developed for each resident.</p> <p>Review of Resident's #9's medical record revealed the facility admitted Resident #9 on 06/18/13 with diagnoses that included</p>	F 282	<p>F253 Correction continued:</p> <p>4. The Housekeeping Supervisor, Administrator, and Plant Operations Director will present findings from environmental rounds to the Facility Quality Assurance Performance Improvement (QAPI) Committee monthly. The committee will track and trend information from the reports and provide recommendations on ways to improve the quality of services provided.</p> <p>F282 Correction:</p> <p>1. On 11/8/2014 the Unit Manager implemented the written plan of care for resident #9 including the use of TED hose and chair alarm as ordered by the physician and as listed on the plan of care. The Unit Manager reviewed the resident's plan of care to ensure that all other interventions listed on the care plan was being implemented and no concerns were identified. The Unit Manager d/c the chair alarm per MD order on 11/14/14. On 11/25/14 the MDS Coordinator updated the care plan to better reflect that the resident refused to wear her TED hose at times and provided interventions to encourage her to wear them.</p> <p>2. The Unit Managers, Director of Nursing, and MDS Coordinators will conduct an audit of all written plans of care for residents at the facility by 12/2/2014 and will ensure these interventions are being implemented and ensure the comprehensive plan of care matches the SRNA plan of care. Any instances where care is not being provided in accordance with the written plan of care will be immediately corrected and reported to the administrator. Dates will be added to the SRNA care plans so they can easily identify the current plan.</p> <p>3. The Director of Nursing will provide additional education to the Unit Manager for that unit regarding her responsibility to monitor the implementation of care plans by 12/2/2014. The Director of Nursing will complete at least three random resident observations per week on each unit to ensure care plan implementation. This will be completed 3 per week for 4 weeks, then 2 per week for 4 weeks then 1 per week for 4 weeks. Any failure to implement care plan implementations will be immediately</p>	12/2/14	

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

PRINTED: 11/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/07/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIBERTY CARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539</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	
F 282	<p>Continued From page 3</p> <p>Osteoarthritis, Advanced Chronic Obstructive Pulmonary Disease, Bipolar Disorder, Hypertension, and Chronic Psychiatric Illness. Review of the Minimum Data Set (MDS) quarterly assessment dated 09/10/14 revealed the resident's Brief Interview for Mental Status (BIMS) score was 13, which indicated the resident was interviewable.</p> <p>Review of Resident #9's Comprehensive Care Plan dated 09/11/14 revealed a wheelchair alarm would be on Resident #9's wheelchair because the resident had decreased safety awareness. In addition, a review of the Nurse Aide Care Plan (not dated) revealed Resident #9 was required to have TED hose on during the morning when up in a wheelchair, and off in the evening when in bed.</p> <p>Observations of Resident #9 on 11/05/14 at 5:25 PM, 11/06/14 at 10:35 AM, and 11/06/14 at 12:35 PM revealed Resident #9 was sitting in a wheelchair. Resident #9 did not have a chair alarm and was not wearing TED Hose as required by the resident's care plan.</p> <p>Interview with State Registered Nurse Aide (SRNA) #2 on 11/07/14 at 7:50 PM revealed she provided care for Resident #9 on 11/05/14 and 11/06/14 and was not aware that the resident was required to have a chair alarm on his/her wheelchair. The SRNA stated the resident was not wearing TED hose because the resident usually stayed in bed.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 11/07/14 at 6:15 PM revealed that Resident #9 refused to wear TED hose most of the time. The LPN further stated a wheelchair alarm should have been in use for the resident.</p>	F 282	<p>F282 Correction Continued: corrected and reported to the Administrator. During quarterly care plan reviews the MDS Coordinator will review residents to ensure written plans of care are being implemented and that comprehensive plans of care match the SRNA plan of care. Any identified concerns will be immediately corrected and reported to the administrator. This will be an on-going intervention. The Director of Nursing, SDC, and MDS Coordinators will provide training to all nursing staff on the requirement to ensure written plans of care are implemented by 12/2/2014.</p> <p>4. The Director of Nursing and MDS Coordinators will report audit findings to the Quality Assurance Performance Improvement (QAPI) committee each month. The Committee will review, track and trend any concerns identified in the audits and make recommendations for quality improvements as indicated.</p>		

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

PRINTED: 11/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/07/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIBERTY CARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539</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
F 282	Continued From page 4	F 282		
F 323 SS=D	<p>Interview with Registered Nurse/Unit Manager #1 on 11/07/14 at 6:25 PM revealed that if there was an intervention for a wheelchair alarm on the care plan, then it should have been on the wheelchair.</p> <p>Interview with the Director of Nursing on 11/07/14 at 6:30 PM revealed staff should follow the care plan.</p> <p><b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b></p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy it was determined the facility failed to ensure one (1) of twenty (20) residents (Resident #9) was free from accident hazards. Resident #9's facility developed care plan required staff to utilize a chair alarm on the resident's chair to prevent falls because of the resident's decreased safety awareness. Observations on 11/05/14 and 11/06/14 revealed the resident was not utilizing a chair alarm.</p> <p>The findings include:  Review of the facility's policy titled "Fall Policy," dated April 2012, revealed a comprehensive care</p>	F 323	<p><b>F323 Correction:</b></p> <ol style="list-style-type: none"> <li>On 11/8/2014 the Unit Manager implemented the written plan of care for resident #9 including the use of chair alarm as ordered by the physician and as listed on the plan of care. The Unit Manager reviewed the resident's plan of care to ensure that all other interventions listed on the care plan was being implemented and no concerns were identified. The Unit Manager d/c the chair alarm per MD order on 11/14/14.</li> <li>The Unit Managers, Director of Nursing, and MDS Coordinators will conduct an audit of all written plans of care for residents at the facility by 12/2/2014 and will ensure these interventions are being implemented including all interventions to ensure residents are free of accidents and hazards and to ensure adequate supervision and assistance devices to prevent accidents. They will also ensure the comprehensive plan of care matches the SRNA plan of care. Any instances where care is not being provided in accordance with the written plan of care will be immediately corrected and reported to the administrator. Dates will be added to the SRNA care plans so they can easily identify the current plan.</li> <li>The Director of Nursing will provide additional education to the Unit Manager for that unit regarding her responsibility to monitor the implementation of care plans by 12/2/2014. The Director of Nursing will complete at least three random resident observations per week on each unit to ensure care plan implementation, including implementation of interventions to ensure the environment remains as free of accident hazards as possible and interventions to ensure each resident receives adequate supervision and assistance devices to prevent accidents. This will be completed 3 per week for 4 weeks, then 2 per week for 4 weeks, then 1 per week for 4 weeks. Any failure to implement care plan implementations will be immediately corrected and reported to the Administrator. During quarterly care plan reviews the MDS Coordinator will review residents to ensure written plans of care are being implemented and that comprehensive plans of care match the SRNA plan of care. This review will include a review of interventions to ensure the environment remains as free of accident hazards as possible and interventions to ensure each resident receives adequate supervision and assistance devices to prevent accidents. Any identified concerns will be immediately corrected and reported to the administrator. The Director of Nursing, SDC, and MDS Coordinators will provide training to all</li> </ol>	12/2/14

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

PRINTED: 11/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/07/2014
NAME OF PROVIDER OR SUPPLIER  LIBERTY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 616 S WALLACE WILKINSON BLVD LIBERTY, KY 42639		
(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 323	<p>Continued From page 5</p> <p>plan would be implemented with an individualized goal and interventions specific to each resident. Further review revealed the facility would provide residents with assistance and supervision in an effort to minimize the risk of falls and fall related injuries.</p> <p>Review of Resident's #9's medical record revealed the facility admitted Resident #9 on 06/18/13 with diagnoses that included Osteoarthritis, Advanced Chronic Obstructive Pulmonary Disease, Bipolar Disorder, Hypertension, and Chronic Psychiatric Illness. Review of the Minimum Data Set (MDS) quarterly assessment dated 09/10/14 revealed the resident's Brief Interview for Mental Status (BIMS) score was 13, which indicated the resident was interviewable.</p> <p>Review of Resident #9's comprehensive care plan dated 09/11/14 revealed the facility identified that the resident had decreased safety awareness and was at risk for falls. The facility identified that the resident required the use of a wheelchair alarm as an intervention to decrease/prevent falls.</p> <p>Observations of Resident #9 on 11/05/14 at 5:25 PM, 11/06/14 at 10:35 AM, and 11/06/14 at 12:35 PM revealed Resident #9 was sitting in a wheelchair, but did not have an alarm on the wheelchair as required by the resident's care plan.</p> <p>On 11/07/14 at 7:50 PM an interview with State Registered Nurse Aide (SRNA) #2, who provided care for Resident #9 on 11/05/14 and 11/06/14, revealed she was not aware that Resident #9 was required to have a chair alarm on his/her</p>	F 323	<p>F323 Correction continued: staff on the requirement to read and ensure written plans of care are implemented and that all safety interventions are in place by 12/2/2014.</p> <p>4. The Director of Nursing and MDS Coordinators will report audit findings to the Quality Assurance Performance Improvement (QAPI) committee each month. The Committee will review, track and trend any concerns identified in the audits and make recommendations for quality improvements as indicated.</p>		

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

PRINTED: 11/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/07/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIBERTY CARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539</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	
F 323	Continued From page 6 wheelchair. The SRNA stated she was required to check the comprehensive plan of care at the beginning of every shift and had not been aware a chair alarm was required to be on Resident #9's wheelchair. The SRNA stated the chair alarm was not on the nurse aide plan of care, and she had just missed it on the comprehensive plan of care.  Interview with Registered Nurse (RN)/Unit Manager #1 on 11/07/14 at 6:25 PM revealed care plans should be implemented and she made rounds frequently throughout the day to ensure staff was providing the care residents required, but had not identified that Resident #9 did not have a chair alarm on his/her wheelchair. The Unit Manger further stated the nurse aide care plan should have included the requirement for a chair alarm for Resident #9 and she should have identified that it did not.  Interview with the Director of Nursing (DON) on 11/07/14 at 6:30 PM revealed that if the care plan required a chair alarm, then the alarm should have been on the wheelchair. The DON stated the chair alarm for Resident #9 should have been on the comprehensive plan of care, as well as the nurse aide plan of care. The DON stated the Unit Manager was responsible for ensuring the comprehensive plan of care and the nurse aide plan of care matched.	F 323	F366 correction:  1. Resident #7 and Resident #10 were provided with a substitute for the pinto beans on 11/6/2014 and unit manager #1 and SRNA #1 were educated on 11/6/2014 regarding checking for dislikes when serving meals and the requirement to provide a substitute of similar nutritive value. Resident #7 and Resident #10 have had their food preferences verified and preference documentation has been updated by the dietary manager. 2. Random meal service audits were conducted from 11/7/14 to 11/14/14 by members of the facility management staff with no additional instances of disliked food items being served to residents. The food preference forms for all residents at the facility will be updated by 12/2/14 to ensure all dislikes are properly identified. This will be overseen by the dietary manager. 3. The SDC, Director of Nursing, Unit Managers, MDS Coordinators, and the Administrator will conduct training with all staff by 12/2/14 regarding the requirement to properly identify food dislikes and to offer substitutes of similar nutritive value to residents who dislike a food being served. They will also provide training with all staff on reading the tray cards. The dietary manager will complete an audit of all tray cards to ensure accuracy by 12/2/2014. Any identified errors will be immediately corrected. The dietary manager will conduct at least 10 random audits per week beginning 11/29/2014 to ensure disliked foods are not placed on resident trays. This will be completed for at least 4 weeks, then 5 audits will be completed per week for 4 weeks then 3 audits for 4 weeks. Any identified instances of disliked food being placed on a resident tray will be immediately corrected and reported to the administrator. The dietary manager and dietary staff were educated by the administrator on the requirement to properly identify and offer substitutes of similar nutritive value for disliked food items. The social services director and/or quality of life director will ask residents about substitutes being provided for disliked items during the monthly resident council and will address any concerns through the grievance process and will notify the administrator. This will begin with the December resident council meeting and will be on-going for a minimum of three months.	12/2/14	
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE  Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.	F 366			

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

PRINTED: 11/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/07/2014
NAME OF PROVIDER OR SUPPLIER  LIBERTY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 366	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure substitutes were offered to residents that had identified food dislikes for two (2) of twenty (20) sampled residents (Resident #7 and Resident #10). Resident #7 and Resident #10 disliked pinto beans; however, on 11/06/14, at the lunch meal service staff was observed to serve pinto beans to both residents.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Resident Food Preferences," with a revision date of December 2008, revealed upon a resident's admission to the facility, the Registered Dietitian (RD) or nursing staff would identify a resident's food preferences. The policy stated the facility would offer a number of food substitutes for individuals who did not want to eat the primary meal. The policy revealed staff would strive to accommodate a resident's preferences.</p> <p>1. Observation of Resident #10 on 11/06/14, at 12:35 PM, revealed Unit Manager #1 served the resident pinto beans on his/her meal tray. Review of the meal tray card for Resident #10 revealed the resident disliked pinto beans.</p> <p>Interview conducted with Resident #10 on 11/06/14, at 12:40 PM, revealed, "I do not like pinto beans and I have told the staff several times. I was not asked if I wanted a substitute for the pinto beans."</p> <p>Interview conducted with Unit Manager #1 on</p>	F 366	<p>F366 Correction Continued: The Unit Managers will conduct at least 6 random checks of meals being served to residents per week for each unit beginning 12/2/2014 for 4 weeks, then 3 random checks per unit for 4 weeks then 2 random checks per unit for 4 weeks to ensure that dislikes are not being served and that substitutes of similar nutritive value is being provided for disliked food items and to ensure staff are reading the tray cards prior to giving meals to residents. Any identified problems will be immediately corrected and reported to the administrator. 4. The Dietary Manager, SSD, and Unit Managers will provide the results of audits to the facility Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis. The committee will track and trend the data provided and make recommendations as needed for any identified concerns to improve quality of services provided.</p>		

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

PRINTED: 11/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>186408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/07/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIBERTY CARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539</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	
F 366	<p>Continued From page 8</p> <p>11/06/14, at 12:45 PM, revealed she stated she had not identified that Resident #10 did not like pinto beans and she should have checked the resident's tray card.</p> <p>2. Observation of Resident #7 on 11/06/14, at 12:50 PM, revealed State Registered Nurse Aide (SRNA) #1 served the resident pureed pinto beans on his/her meal tray. Review of the meal tray card for Resident #7 revealed the resident disliked pinto beans.</p> <p>An interview was attempted with Resident #7 on 11/06/14, at 12:52 PM, and the resident did not respond.</p> <p>Interview with SRNA #1 on 11/06/14, at 12:55 PM, revealed he had not checked the resident's tray card but should have prior to attempting to feed the resident.</p> <p>Interview conducted with the RD on 11/07/14, at 3:00 PM, revealed the Dietary Aide was responsible for telling the Cook during tray line of any dislikes a resident may have. The RD stated she monitored with spot checks for likes and dislikes being honored. The RD stated she checked five to seven trays every month and had not identified any concerns with resident's likes and dislikes not being honored.</p> <p>Interview conducted with Dietary Aide #1 on 11/06/14, at 3:07 PM, revealed she was responsible for notifying the Cook of the likes and dislikes of Resident #7 and Resident #10 for the lunch meal on 11/06/14. The Dietary Aide stated it was an oversight and Resident #7 and Resident #10 should not have been served pinto beans on their meal tray.</p>	F 366			

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

PRINTED: 11/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/07/2014
NAME OF PROVIDER OR SUPPLIER  LIBERTY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 366	Continued From page 9	F 366			
F 371 SS=E	<p>Interview conducted with the Director of Nursing (DON) on 11/07/14, at 4:55 PM, revealed staff was required to check a resident's meal card when serving trays to ensure likes and dislikes were being honored, and to ensure the correct diet was being served. The DON stated she monitored at least 25 trays every week to ensure residents' likes and dislikes were being honored, and had not identified any concerns.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to prepare and distribute food in a sanitary manner and failed to maintain a clean area for storage of pots and pans. Observation during the initial tour of the kitchen on 11/05/14 at 1:05 PM revealed a greasy substance and food particles on the metal carts used to store pots and pans. In addition, on 11/05/14 during the evening meal the Cook and Dietary Aide #2 were observed to touch their clothing/skin and return to serve residents' food without washing their hands.</p>	F 371	<p>F371 Correction:</p> <ol style="list-style-type: none"> <li>On 11/8/2014 the kitchen area, including the metal carts used to store pots and pans, corners and edges was deep cleaned by the dietary manager. On 11/8/2014 the staff development coordinator provided additional education to all dietary staff including the manager, Dietary Aide #2, and the cook on maintaining a sanitary environment, hand washing requirements and the facility requirement to store, prepare, distribute and serve food under sanitary conditions.</li> <li>The dietary manager completed a minimum of 10 observations of meal service from 11/7/2014 to 11/14/2014 and found no further instances of failure to store, prepare, and serve food in a sanitary environment and manner. She observed no further instances of dietary staff failing to follow hand washing requirements and found no further instances of the dietary environment being unsanitary.</li> <li>All dietary staff were educated by the staff development coordinator on maintaining a sanitary environment, hand washing requirements, and the facility requirement to store, prepare, and serve food in a sanitary environment and manner. This was completed on 11/8/14. The staff development coordinator will conduct on-going education in this area at least annually. The dietary manager will review this requirement with any new staff hired for the department on an on-going basis.</li> </ol> <p>Effective 12/2/2014 the dietary manager will conduct a minimum of 6 sanitation reviews per week using the sanitation review form for 4 weeks, then 3 reviews per week for 4 weeks, then 2 reviews per week for 4 weeks. This includes observation of the environment and staff to ensure the facility is complying with the requirement to store, prepare, distribute and serve food under sanitary conditions. Effective 11/23/14 The Administrator will complete a minimum of 3 weekly environmental rounds for 4 weeks, then 2 rounds for 4 weeks then 1 round for 4 weeks and on-going to include the dietary area and will observe to ensure the area is clean and sanitary including storage areas for pots and pans floors, corners etc. This environmental round will be documented on an environmental round form.</p>	12/2/2014	

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

PRINTED: 11/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/07/2014
NAME OF PROVIDER OR SUPPLIER  LIBERTY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 616 S WALLACE WILKINSON BLVD LIBERTY, KY 42639		
(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 371	<p>Continued From page 10</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Cleaning and Sanitizing Dietary Areas and Equipment," undated, revealed employees in the Dietary Department should maintain all kitchen areas and equipment in a sanitary manner and be free of buildup of food, grease, or other soil. The policy revealed the Dietary Manager was responsible to ensure the policy was followed. Review of the facility's policy titled "Handwashing," dated 12/2010, for the Clinical Department revealed staff was required to wash their hands before handling a resident's food or food tray.</p> <p>Interview with the Dietary Manager and Registered Dietitian (RD) on 11/06/14, at 12:30 PM, revealed the facility did not have a policy regarding handwashing specific to Dietary staff. Review of the Dietary Services cleaning schedule revealed the kitchen aides were required to clean the utility carts twice daily. Review of the Nutrition Services Sanitation/Food Safety Checklist completed monthly by the RD, dated 10/13/14, identified the utility carts were not clean.</p> <p>Observations of the kitchen during the initial tour on 11/05/14 at 1:05 PM, revealed a greasy substance and food particles were on the metal utility carts used to store pots and pans. Observation of the supper tray line on 11/05/14, at 4:50 PM revealed the Cook was serving food trays and touched her face with her bare hands several times and scratched her shoulder, and proceeded to continue serving food without washing/sanitizing her hands. Observation of the tray line at the supper meal on 11/05/14, at 5:26 PM, revealed Dietary Aide #2 wiped her bare</p>	F 371	<p>F371 Correction Continued:</p> <p>4. The Dietary Manager, Registered Dietitian, and Administrator will provide the results of dietary audits to the Facility Quality Assurance Performance Improvement (QAPI) Committee for review. The Committee will track and trend audit results and make recommendations for quality improvement as indicated.</p>		

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

PRINTED: 11/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/07/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIBERTY CARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>616 S WALLACE WILKINSON BLVD LIBERTY, KY 42639</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	
F 371	<p>Continued From page 11</p> <p>hands on her pants, and adjusted her waistband, and proceeded to return to the tray line without washing/sanitizing her hands.</p> <p>Interview conducted with Dietary Aide #2 on 11/05/14, at 5:45 PM, revealed she was required to wash/sanitize her hands before and after serving food from the tray line. Dietary Aide #2 stated she should have washed her hands after touching any body part or clothing. Dietary Aide #2 stated she had attended in-services provided by the facility on hand washing/sanitizing and was aware she should have washed her hands any time she touched anything unsanitary before returning to the tray line.</p> <p>Interview conducted with the Cook on 11/05/14, at 5:50 PM revealed she had attended in-services on handwashing/sanitizing quarterly, provided by the facility, and was aware she should have washed her hands any time she touched her body, clothing, or anything outside of the tray line.</p> <p>Interview with the Dietary Manager on 11/06/14, at 12:35 PM, revealed the Dietary Manager checked the cleaning log daily and looked over the kitchen to ensure it was cleaned properly according to policy. The Dietary Manager stated she had reminded all kitchen staff about handwashing. The Dietary Manager stated she was unsure how often staff was in-serviced on handwashing/sanitation since she was new to the position as Dietary Manager.</p> <p>Interview with the Registered Dietitian (RD) on 11/06/14 at 12:30 PM, revealed she completed a check-off list monthly titled "Nutrition Services Sanitation/Food Safety Checklist," and had identified on the most recent checklist dated</p>	F 371			

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

PRINTED: 11/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/07/2014
NAME OF PROVIDER OR SUPPLIER  LIBERTY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 12 10/13/14, that the metal utility carts were dirty and the corners of the kitchen were dirty. The RD stated she provided this report to the Dietary Manager and Administration.	F 371			
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 observation, interview, record review, and facility policy review, it was determined the facility failed to obtain laboratory services to meet the needs of one (1) of twenty (20) sampled residents (Resident #3). Resident #3 had a physician's order dated 03/12/14 for a Magnesium (electrolyte) laboratory level to be drawn every three months, in March, June, September, and December. However, review of Resident #3's medical record revealed no evidence a Magnesium level had been obtained in June 2014.  The findings include:  Review of the facility's policy titled "Ordering of Lab Work and Xrays," dated December 2010, revealed residents who required laboratory or radiological services would receive the services within a timely manner. The policy stated that for a routine laboratory order, the licensed nurse would be responsible for entering the order into the computer to be done on the next day.	F 502	1. Resident #3's physician was notified of the missed Magnesium (electrolyte) laboratory level that was due in June on 11/7/2014 by the unit manager and the physician instructed the facility to continue with current orders, including current laboratory orders. The Magnesium laboratory order was clarified/changed to be completed every six months. ( By the unit manager and physician on 11/7/2014) On 11/7/2014 Resident #3's medical record was reviewed by the unit manager and all other physician orders, including laboratory orders were in compliance and the laboratory results from the September 2014 Magnesium level was reviewed and was within normal limits. Resident #3's family was notified of the missed laboratory level on 11/7/2014 by the unit manager. 2. An audit will be completed by the Director of Nursing and unit managers by 12/2/2014 for all current physician's orders for laboratory services for all residents currently admitted to the facility to ensure facility compliance with laboratory orders. Any resident identified during the audit with laboratory orders that were not completed in accordance with the physician's orders will be reported to the administrator, physician, and family and the facility will follow physician orders to correct any identified oversight. 3. The Director of Nursing provided education to the unit manager who was responsible for monitoring the laboratory orders for resident #3 on 11/23/2014 regarding the unit manager's responsibility to monitor laboratory order compliance for residents on her unit. Effective 11/23/2014 all laboratory orders will be reviewed daily Monday-Friday by the management team during the morning meeting. New laboratory orders will be written on the white board in the staff development conference room with the name of the resident, date the order was written, and for orders to be completed in the future the date when it should be completed. The management team will review these orders and completed laboratory results daily Monday through Friday and will mark the order off the board when complete.	12/2/14	

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

PRINTED: 11/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/07/2014
NAME OF PROVIDER OR SUPPLIER  LIBERTY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 502	<p>Continued From page 13</p> <p>Observation of Resident #3 on 11/05/14, at 4:10 PM, revealed the resident was sitting up in a wheelchair in the dayroom watching television.</p> <p>Review of the medical record for Resident #3 revealed the facility admitted the resident on 03/25/13, with diagnoses that included Hypertension, Atrial Fibrillation, Dementia, and Gastroesophageal Reflux Disease.</p> <p>Review of physician's orders for Resident #3 revealed a physician's order dated 03/12/14, for a Magnesium (electrolyte) laboratory level to be drawn every three months, in March, June, September, and December.</p> <p>Review of laboratory reports for Resident #3 revealed the facility had obtained a Magnesium (electrolyte) level on 03/11/14, and there was no documentation in the medical record that another Magnesium level was obtained until 09/01/14.</p> <p>Interview with Unit Manager #1 on 11/07/14, at 10:50 AM, revealed she was responsible for placing the order in the computer for Resident #3's Magnesium laboratory level. The Unit Manager also stated she was responsible for monitoring residents' laboratory tests on the North Wing to ensure the laboratory tests were completed as ordered by the physicians. The Unit Manager did not have an explanation for why the test for Resident #3 was missed.</p> <p>Interview conducted with the Director of Nursing (DON) on 11/07/14, at 4:55 PM, revealed the Unit Managers were required to monitor all laboratory tests and review all residents' medical records every month to ensure all laboratory testing had been completed as ordered by the physician.</p>	F 502	<p>F502 correction continued: (Management team members may include but are not limited to the Administrator, DON, Unit Managers, SSD, MDSC, Medical Records, etc.) In addition to this monitoring, the unit managers will continue to be responsible for monitoring the timely follow-up to all laboratory orders and their work will be supervised by the Director Of Nursing. The Staff Development Coordinator and Director of Nursing will complete reminder education to all nurses about the requirement to follow all physician's orders for laboratory services in a timely manner. This will be completed by 11/30/2014. An audit tool will be utilized to complete a weekly laboratory follow-up audit for a period of at least three months (12 weeks). This audit will be completed by the Director of Nursing, Unit Managers, and Medical Records Director.</p> <p>4. The Unit Managers will provide a report to the Facility Quality Assurance Performance Improvement (QAPI) team on a monthly basis listing the total number of new laboratory orders for the month, the total laboratory services provided by the facility, and the total number (if any) that were not completed in a timely manner. The results of the weekly audit will be presented to the QAPI committee by the Director of Nursing. The QAPI team will track and trend any laboratory services that are not completed timely and will make recommendations as needed to improve the quality of services provided. The Director of Nursing will complete a random review of at least three laboratory orders per unit each month to ensure compliance with physician orders through a chart review. The results of this review will be shared with the QAPI team and administrator at least monthly. The Administrator is responsible for overall compliance.</p>		

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

PRINTED: 11/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/07/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIBERTY CARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539</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	
F 502	Continued From page 14 The DON stated she had not been aware of any missed laboratory tests.	F 502			