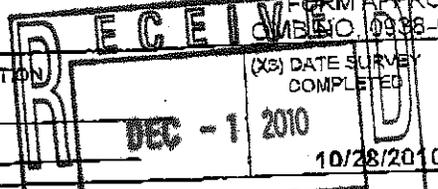


Amended 50D

PRINTED: 11/24/2010

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

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 10/28/2010
--	--	--	--



NAME OF PROVIDER OR SUPPLIER WEST LIBERTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 774 LIBERTY ROAD, WEST LIBERTY, KY 40372 Division of Health Care Southern Enforcement Branch
--	---

(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 157 SS=D	<p>**AMENDED--</p> <p>A standard health survey was conducted on October 28-28, 2010. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident, consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	<p>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.</p> <p>West Liberty Nursing and Rehabilitation strives to immediately inform the resident, consult with physician and if known, resident's legal representative or family member when there is an accident involving the resident resulting in injury.</p> <p>The physician and family for resident number 2 were notified of the incident on 10-25-10 at 3:40 pm by L.P.N. The facility received orders from the physician for an x-ray on 10/25/10 and for a consult by an outside specialist on 10/26/10. The consult was scheduled for 10/29/10. Though the resident had PRN medication ordered, which was effective, the charge nurse obtained orders from the physician on 10-27-10 regarding scheduled pain medications for 48 hours. The resident visited an outside specialist on 10-29-10 and his written report indicates that there was no fracture. The</p>	12/03/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Samela J. Burton</i>	TITLE Administrator	(X6) DATE 12/01/10
--	------------------------	-----------------------

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.

Received Time Dec. 1, 2010 10:57AM No. 4666

PRINTED: 11/24/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/28/2010
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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to notify the physician and the responsible party after a significant change in the resident's health status and a need to alter treatment for one (1) of sixteen (16) sampled residents (resident #2). While being transferred with a mechanical lift at approximately 10:00 a.m. on October 25, 2010, resident #2's right foot hit the bed frame. The staff assisting resident #2 failed to report the incident to nursing staff. The resident complained of pain at 3:40 p.m., the physician was notified, and the resident was sent for x-rays. The results of the x-ray revealed fractures to three toes on the resident's right foot. The findings include: Review of resident #2's medical record revealed diagnoses which included Chronic Obstructive Pulmonary Disease, Hypertension, Coronary Artery Disease, Depression, Osteoporosis, B-Complex Deficit Anemia, Asthma, Esophageal Reflux, Arterial Sclerotic Vascular Disease, and Congestive Heart Failure. A Minimum Data Set (MDS) assessment dated July 14, 2010, revealed resident #2 required two staff for safe transfers and was required to be lifted by mechanical lift. Review of the nursing notes for October 25, 2010, at 3:40 p.m., revealed resident #2 complained of pain in the right foot. The resident told the nurse the CNAs let her foot hit the bed when they obtained the resident's weight. According to the nursing notes the resident stated, "It's broke, I	-F 157	report indicates that the resident has severe osteoporosis and some arthritis but had no clinical signs of a fracture and the x-rays obtained in his office did not support a fracture. He also reviewed the films that were interpreted at Appalachian Regional Hospital on October 25, 2010. He could not appreciate any fractures on that film. The policy and procedure for reporting accidents and incidents was reviewed by the Administrator and DON on 10-27-10. No changes were made to this policy. Additionally, the policy for Physician Notification and Significant Change in Condition were reviewed by the Administrator and DON on 10-27-10. No changes were made to these policies. The SRNA's involved in the incident regarding resident #2 received disciplinary actions by Director of Nursing on 10-28-10 and 10-29-10. Additionally, these SRNA's received one-on-one education by Director of Nursing on 10-28-10 and 10-29-10 regarding the appropriate facility reporting procedures. All staff received additional education regarding the facility's policy of reporting accidents/ incidents by Director of Nursing on 11-19-10. Additionally, nursing staff received additional education on 11-19-10 by Director of Nursing regarding the facility policies related to Physician Notification and Significant Change in Condition notification.		

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

PRINTED: 11/24/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/28/2010
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 157	<p>Continued From page 2</p> <p>heard it crack." The note reflected the physician and responsible party were notified of the complaint and orders received for an x-ray of the right foot. The nursing notes dated October 26, 2010, at 6:00 p.m., indicated the results of the right foot x-ray were received. The physician was notified and orders for an orthopedic consult were received.</p> <p>A review of the x-ray report obtained October 25, 2010, and read/released October 26, 2010, at 10:57 a.m., revealed: Arthritis in the ankle joint and tarsal bones; a fracture through the base of the proximal phalanx of the fourth toe, third toe and probably fifth toe, and also a hairline fracture through the base of the fifth metatarsal. An impression was included from the radiologist which stated, "Multiple fractures involving the toes which are non displaced. Severe Osteoporosis."</p> <p>Interview with resident #2's family on October 27, 2010, at 9:45 a.m., revealed the family was not made aware of the incident related to the injury to resident #2's right foot until October 25, 2010, around 3:40 p.m.</p> <p>Interview with CNAs #1, #2, and #3 on October 27, 2010, from 1:20 p.m. until 3:45 p.m., revealed on October 25, 2010, the CNAs weighed resident #2 using a mechanical lift. The CNAs stated the lift was functioning correctly, however, when resident #2 was being returned to bed, the resident's foot hit the bed, and the resident complained of pain. The interviews revealed each CNA thought one of the other CNAs had reported the incident. However, none of the CNAs reported the injury to resident #2's right foot to nursing staff.</p>	F 157	<p>LPN charge nurses completed a body audit of all residents by 10-29-10 to determine that any injuries had been reported timely. Additionally, each interviewable resident was questioned by LPN charge nurses on 10-29-10 to determine that any injury or incident had been reported and recorded appropriately. The nursing staff observations and/or interviews revealed no further incidents/injuries that had not been previously reported.</p> <p>The DON/designee will do five random body audits and/or resident interviews each week for four weeks to determine if resident accidents/incidents are being reported appropriately.</p> <p>The results of these audits will be discussed weekly in the Focus Meeting (a sub-committee of the Continuous Quality Improvement Committee).</p> <p>The results will also be forwarded to the monthly Continuous Quality Improvement Committee Meeting (CQI) for further monitoring and continued compliance.</p>		

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

PRINTED: 11/24/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/28/2010
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 167	Continued From page 3 Interview with LPN #1 on October 27, 2010, at 1:50 p.m., revealed no incident regarding resident #2 was reported by any of the CNAs on October 25, 2010; on the first shift. Interview with LPN #2 on October 27, 2010, at 4:20 p.m., revealed on October 25, 2010, at 3:40 p.m., resident #2 complained of pain to the right foot and reported the incident of the CNAs hitting the resident's right foot earlier that day. LPN #2 stated the physician was contacted and orders were received to have an x-ray of the right foot. LPN #2 contacted resident #2's family and Emergency Medical Services (EMS) and resident #2 left the facility for an x-ray of the right foot. LPN #2 stated an incident report was started after the LPN was notified approximately five and one-half hours after the injury occurred. An interview with the DON on October 28, 2010, at 1:45 p.m., revealed the conclusion of the investigation of resident #2's injury was that CNAs #1, #2, and #3 should have reported the incident immediately, and the CNAs received disciplinary action of a one-day suspension.	F 157			
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.	F 167	West Liberty Nursing and Rehabilitation Center strives to make survey results available for examination and post notice of their availability. The survey book was placed back into the Morgan Room (a family room for residents and visitors) by Social Services on 10-28-10. Signage was posted in the main hallway by Social Services on 10-28-10 to alert family/residents as to the location of the survey information for the last three years.	12/03/10	

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

 PRINTED: 11/24/2010
 FORM APPROVED
 OMB NO. 0938-0391

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 10/28/2010
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 167	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the previous survey results were available for examination, in a place readily accessible to residents and the public. Additionally, the facility failed to post a notice of the availability of the survey results. The findings include: Observations during the annual survey on October 26, 2010 thru October 28, 2010, revealed no notice was posted to inform residents and the public that survey results were available for examination. Continued observation revealed the survey results were not readily available for examination/review. Eleven residents attended the Quality of Life group interview on October 27, 2010, at 1:30 p.m. All 11 residents stated they were unsure of the location of the facility survey results. Interview with the Administrator on October 28, 2010, at 2:00 p.m., revealed the survey results were routinely kept in the Morgan Room (a lounge) where residents and family members could review the results. The Administrator stated no one had been assigned to ensure the survey results remained in the Morgan Room. The Administrator stated a notice should be posted at the nurses' station indicating the results were in the Morgan Room.	F 167	The guidelines regarding the posting of survey information was reviewed by the Administrator and CQI Director on 10-28-10. The administrator received additional education by the CQI Director on 11-15-10 regarding the guidelines for providing the public with survey information as outlined in the Federal Regulations. The Administrator will audit the placement of appropriate signage and survey information booklet daily (Monday-Friday) for four weeks via daily compliance rounds. The results of these audits will be discussed weekly in the Focus Meeting (a sub-committee of the Continuous Quality Improvement Committee). The results will also be forwarded to the monthly Continuous Quality Improvement Committee Meeting (CQI) for further monitoring and continued compliance.	
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	F 248	West Liberty Nursing and Rehabilitation strives to provide an ongoing program of activities designed to meet, in accordance	12/03/10

PRINTED: 11/24/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/28/2010
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 248	<p>Continued From page 5</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide an ongoing program of activities for the individually assessed needs of two (2) of sixteen (16) sampled residents (residents #3 and #6). The facility had identified activities of interest for residents #3 and #6, however, failed to provide the identified activities for the residents. In addition, the facility failed to provide planned activities on the weekends or when the Activity Director was not scheduled to work during the week.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the record revealed resident #3 was readmitted to the facility on April 4, 2010, with diagnoses of Acute Renal Failure, Diabetes Insipidus, Congestive Heart Failure, and Bipolar Disorder. Review of the Quarterly Minimum Data Set (MDS) assessment dated September 23, 2010, revealed the facility assessed resident #3 as being moderately impaired in daily decision-making. Further review of the assessment revealed the facility assessed resident #3 as being involved in activities one-third to two-thirds of the time. <p>Review of the Activity Assessment/Interest Inventory Sheet dated April 27, 2009, revealed</p>	F 248	<p>with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>The Activity Director has reviewed the activity preferences for resident #3 and #6 on 11/19/10. She has discussed the preferences with each resident and has incorporated activities into the resident plan of care that is meaningful, appropriate and realistic for that resident.</p> <p>The Activity Director has reviewed the activity preferences for all residents in the facility on 11/22/10. The plan of care for all residents has been reviewed and will be updated by 12/1/10 to ensure that the care plan reflects the individual activity interests of that resident, based on resident and/or family interview.</p> <p>The Administrator provided additional education to the Activity Director on 11-10-10 regarding the importance of providing an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident.</p> <p>The Activity Calendar for the month for November was reviewed and revised on 11-19-10 by the Administrator and the Activity Director. The revised calendar includes a larger variety of activities, organized evening activities, and organized activities during the week-end.</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 11/24/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/28/2010
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 248	<p>Continued From page 6</p> <p>resident #3 had been assessed to enjoy 14 of the listed activities. These activities included bingo, bird feed/watch/identify, church related activities, children visiting/teaching, crafts/woodworking, community service/volunteering, conversing/socializing, dancing watch/participate, farming, fishing/hunting, food related activities, music/singing/instruments, personal grooming, plants/gardening, and flower arranging.</p> <p>Review of the Comprehensive Care Plan (updated September 29, 2010) revealed a goal that resident #3 would participate in two one-on-one room activities each week and one group activity each week. Further review of the Comprehensive Care Plan revealed a personal activity schedule would be posted in resident #3's room and the activities provided would be recorded on the flow sheet.</p> <p>Observation during the survey on October 26, 2010 to October 28, 2010, revealed resident #3 was not involved in any activities. Further observation revealed two forms related to activities were taped on the inside of resident #3's closet door. Review of the forms revealed the Activity Care Card listed resident #3's interests as conversing/socializing and reminiscing. The second sheet was the October 2010 One-on-One Activity/In-Room Program that listed the date the activity was provided, time spent in the in-room activity, a description of the activity/resident response, and signature of who provided the activity. Further review of the sign-in activity sheet for October 2010 revealed no entry had been made to indicate an activity had been provided for resident #3. Review of the August 2010 and September 2010 Individual Resident Activities sheet provided by the AD revealed a</p>	F 248	<p>The Administrator/designee will review at least two resident (one-on-one) activity sheets per week for the next eight weeks to ensure that care plan interventions are implemented and recorded appropriately. The Administrator/designee will also audit, via daily compliance rounds (Monday-Friday), that one-on-one activities and group activities are being provided as scheduled. The Administrator/designee will audit week-end activities at least two times per month for the next two months. Additionally, the Administrator/designee will attend monthly resident council meetings for the next three months to ensure that residents are satisfied with the facility activity program.</p> <p>The results of these audits will be forwarded to the weekly Focus meeting. Additionally, they will be forwarded the monthly CQI Committee meeting for further monitoring and continued compliance.</p>		

PRINTED: 11/24/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/28/2010
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 248	<p>Continued From page 7</p> <p>one-on-one activity was provided that consisted of talking/conversing daily from August 1-17, 2010. No activity was recorded for August 18-31, 2010. Review of the Individual Resident Activities sheet dated September 2010 revealed no entry had been made to indicate the activity provided for resident #3 for that month.</p> <p>An interview with resident #3 on October 26, 2010, at 5:45 p.m., revealed resident #3 refused to be out of bed except for a shower. Resident #3 stated the resident enjoyed sewing and would like to have that activity provided. However, sewing had not been offered as an activity for resident #3.</p> <p>Interview on October 27, 2010, at p.m., with the AD revealed resident #3 refused activities except in the resident's room. The AD stated resident #3 had been provided three in-room activities during the survey; however, the AD was unable to provide documentation of the activities provided. The AD stated someone had mentioned to the AD a couple of months ago that resident #3 liked to sew; however, that activity had not been provided for resident #3.</p> <p>2. Interview with resident #6 during initial tour on October 26, 2010, at 11:45 a.m., revealed the resident liked to sew and cook. Resident #6 stated there were not any activities at the facility to interest the resident; however, the resident would like to participate in activities that interested the resident.</p> <p>Review of resident #6's care plan revealed the resident was to have six one-to-one room visits per week and to participate in one group activity per week.</p>	F 248		

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

PRINTED: 11/24/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/28/2010
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 248	<p>Continued From page 8</p> <p>Review of the October 2010 activities participation log revealed no one-to-one room visits had been provided and the resident had participated in no group activities.</p> <p>3. Review of the activities calendar for August, September, and October 2010 revealed no scheduled activities were provided on Saturdays, and on Sundays the only scheduled activity was a church service. The activities calendar for October 2010 revealed no activities to include sewing, baking, or gardening.</p> <p>Further review of the activities calendar revealed in August 2010 no activities were planned after 3:00 p.m. In September 2010, one activity was planned after 3:00 p.m., and in October 2010 two days had planned activities after 3:00 p.m.</p> <p>During a group interview on October 27, 2010, at 1:30 p.m., the residents present stated on the weekends there were no activities. Further interview revealed the only thing to do was to sit around and talk to each other.</p> <p>Observation on October 28, 2010, at 9:00 a.m., of the activities basket revealed there was a small etch-a-sketch, two decks of cards, two small unopened puzzles, and two games.</p> <p>Interview with the Activities Director (AD) on October 28, 2010, at 9:30 a.m., revealed there were no organized activities on Saturdays. The AD stated that there was a basket that contained games residents could play during the evenings, and on weekends; however, the residents had to ask the nursing staff to obtain the games for them and the games had to be self-initiated. The AD</p>	F 248		

PRINTED: 11/24/2010
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: 165274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/28/2010
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 248 F 279 SS=D	<p>Continued From page 9</p> <p>revealed he/she was scheduled to work Monday thru Friday and no individualized activities were available on Saturday and only church services were conducted on Sundays.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop an individualized comprehensive plan of care for two (2) of sixteen (16) sampled residents (residents #6 and #10). Residents #6 and #10 had physician's orders to receive physical therapy (PT) and occupational therapy (OT); however, no care plan was developed to address the PT and OT services. Additionally,</p>	F 248 F 279	<p>West Liberty Nursing and Rehabilitation strives to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>A comprehensive care plan was developed for resident #6 by the IDCPT on 10-29-10. The care plan includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs as identified in the comprehensive assessment. Physical Therapy and Occupational Services have been discontinued for this resident.</p> <p>Resident #10 was discharged to the hospital on 11/10/10. Prior to discharge, the IDCPT team developed a comprehensive care plan on 10-29-10 for this resident that included measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs as identified in the comprehensive assessment. This included a plan of care to address pain. Physical Therapy and Occupational Therapy Services have been discontinued for this resident.</p> <p>The process for the development of a comprehensive care plan has been reviewed</p>	12/03/10

PRINTED: 11/24/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/28/2010
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 279	<p>Continued From page 10</p> <p>resident #10 had a diagnosis of generalized pain for which medication was prescribed; however, the care plan failed to address resident #10's pain.</p> <p>The findings include:</p> <p>1. Review of resident #6's medical record revealed the resident was admitted on September 2, 2010, with a diagnosis of late effect Cerebrovascular Accident, Anxiety State, Depressive Disorder, and Hypertension.</p> <p>Review of resident #6's physician's orders dated October 2010 revealed an order for OT services to treat three times a week for eight weeks, and PT services to treat five times a week for eight weeks.</p> <p>Review of resident #6's comprehensive care plan (CCP) dated September 2, 2010, revealed the CCP did not address the resident's need for PT and OT services as ordered.</p> <p>2. Review of resident #10's medical record revealed the resident was admitted on October 10, 2010, with a diagnosis of Urinary Tract Infection, Deep Vein Thrombosis, Generalized Pain, and Pelvic Fracture. Further review of resident #10's medical record revealed a physician's order for PT services five times a week for eight weeks and OT services five times a week for eight weeks.</p> <p>Review of the MDS (Minimum Data Set) dated October 19, 2010, for resident #10 revealed the resident had been assessed for pain which was present three to four days a week, and as-needed pain medicine was ordered. Further review of the</p>	F 279	<p>by the DON. No changes were made to the process.</p> <p>The DON/designee provided additional education to the licensed nurses and the IDCPT on 11-9-10 regarding the importance of developing a comprehensive plan of care that meets the current needs of the individual resident. This includes measurable objectives and timetables to meet all aspects of the resident's medical, nursing, and mental and psychosocial needs as identified in the comprehensive assessment.</p> <p>The IDCPT reviewed the care plan for each resident on 10-29-10, 11-1-10, and 11-2-10 to determine that each plan of care is reflective of the resident's current medical, nursing, and mental and psychosocial needs as reflected by the comprehensive assessment.</p> <p>The DON/designee will audit five plans of care per week for four weeks to determine that each plan of care has measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs as identified in the comprehensive assessment.</p> <p>The results of these audits will be forwarded to the weekly Focus meeting. Additionally, the results will be forwarded to the monthly CQI meeting for further review and continued compliance.</p>		

PRINTED: 11/24/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/28/2010
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 279	Continued From page 11 medical record revealed a nursing assessment for newly admitted residents dated October 8, 2010. The nursing assessment revealed resident #10 had pain, less than daily in the neck, the intensity was distressing, and the usual pain treatment was a Fentanyl Duragesic patch. Review of resident #10's comprehensive care plan (CCP) dated October 8, 2010, revealed the CCP did not address the resident's need for PT and OT services as ordered. Additionally, the CCP did not address resident #10's diagnosis of pain and the requirement for pain medication. Interview on October 28, 2010, at 11:30 a.m., with the MDS Coordinator, who was responsible for developing the comprehensive plan of care for each resident in the facility, revealed care plans were not created for PT and OT services. The MDS Coordinator further stated an individualized care plan for pain should have been created for resident #10 and did not know why the resident did not have a care plan for pain.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280	West Liberty Nursing and Rehabilitation strives to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment and to ensure care plans are reviewed and updated. The care plan for resident #2 was updated on 10-27-10 by MDS Coordinator to include the use of antibiotics for the UTI. The IDCPT also reviewed the POC to ensure that all interventions were current and reflected the needs of the resident.	12/03/10

PRINTED: 11/24/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/28/2010	
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 280	<p>Continued From page 12</p> <p>and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure comprehensive plans of care were reviewed and or revised for five (5) of sixteen (16) sampled residents (residents #2, #4, #6, #8, and #9). Residents #2 and #9 were started on antibiotics for urinary tract infections, resident #4 was started on a treatment for a skin tear, resident #6 had preventative measures put in place for skin pressure, and resident #8 had fall interventions in place. The comprehensive Plans of Care for these residents were not reviewed/revised to include these interventions.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of resident #2's medical record revealed diagnoses that included Stroke, Congestive Heart Failure, Osteoporosis, and Urinary Retention. Resident #2 had physician's orders for an indwelling catheter for urinary retention. Review of the physician's orders dated October 26, 2010, revealed antibiotic therapy for a urinary tract infection was initiated. <p>A review of the Comprehensive Plan of Care (CPOC) dated June 15, 2009, for resident #2 revealed the resident was at risk for</p>	F 280	<p>The antibiotics for resident #9 were discontinued on 10/16/10. The IDCPT reviewed the plan of care for this resident on 10-29-10 to determine that the care plan was current and reflected the needs of the resident. This included the Guaifenesin Syrup.</p> <p>The skin tear for resident #4 healed on 10/26/10. The IDCPT reviewed the plan of care for this resident on 10-29-10 to determine that the care plan was current and reflected the needs of the resident.</p> <p>The care plan for #6 was revised by the IDCPT on 10-29-10 to reflect the change in preventive care measures to include half side rails and an alarm bracelet. The IDCPT also reviewed the remainder of the care plan to ensure that it was current and reflected the needs of the resident.</p> <p>The care plan for resident #8 was revised by the IDCPT on 10-29-10 to reflect the intervention, stickers added to breaks per therapy that was put into place after the fall on October 23, 2010. Additionally, the care plan was reviewed to ensure that interventions were current and reflective of resident care needs.</p> <p>The DON reviewed the process for revision of the plan of care on 11-10-10. No changes were made to the process.</p> <p>Charge nurses and the IDCPT received additional education by Director of Nursing</p>	

PRINTED: 11/24/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/28/2010
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 280	<p>Continued From page 13</p> <p>complications of indwelling catheter use such as urinary tract infection or injury. A review of the list of interventions revealed the antibiotic ordered October 26, 2010, for a urinary tract infection was not on the CPOC.</p> <p>Observation of resident #2 on October 26, 2010, at 3:15 p.m., revealed amber-colored urine emptying into a bedside drainage bag.</p> <p>Interview on October 28, 2010, at 11:30 a.m., with the Minimum Data Set (MDS) Coordinator, who stated being responsible for updating the CPOCs, revealed the CPOC should have been updated to include the antibiotic usage for resident #2.</p> <p>2. A review of resident #4's medical record revealed diagnoses that included Psychosis, Anxiety, Anemia, Osteoporosis, and Osteoarthritis. Review of the physician's orders dated September 24, 2010, revealed an order for steri-strips to be applied to a right elbow skin tear.</p> <p>A review of the Comprehensive Plan of Care (CPOC) dated February 19, 2010, revealed potential for skin breakdown, with a goal that the resident will maintain intact skin integrity through the next review dated January 19, 2011. A review of the interventions revealed the CPOC was not reviewed/revised to include the treatment for the skin tear to the resident's elbow.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, who stated being responsible for updating the CPOCs, on October 28, 2010, at 11:30 a.m., revealed the CPOC should have been updated to reflect resident #4's treatment for the skin tear.</p>	F 280	<p>on 11-10-10 regarding the importance of revising the care plan for each resident as changes occur in the resident status.</p> <p>The IDCPT reviewed the care plans for each resident on 10-29-10, 11-1-10, and 11-2-10 to determine that all care plans had been revised as the care needs changed for each resident.</p> <p>The DON/designee will review five care plans per week for four weeks to ensure that revisions are recorded on the plan of care as changes in resident care needs occur.</p> <p>The results of these audits will be forwarded to the weekly Focus meeting. Additionally, the results will be forwarded to the monthly CQI meeting for further monitoring and continued compliance.</p>		

PRINTED: 11/24/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/28/2010
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 280	<p>Continued From page 14</p> <p>3. A review of resident #9's medical record revealed diagnoses that included Stroke, Malignant Neoplasm of Pituitary, Gastrostomy-Tube (G-Tube), and Allergies. Resident #9 had physician's orders for Cipro 500 mg per G-tube twice daily for ten days for sinusitis ordered on October 6, 2010. In addition the physician ordered Mucinex 600 mg twice daily. Physician's orders dated October 8, 2010, revealed to discontinue the Mucinex and start Guaifenesin 400 mg per G-tube three times daily.</p> <p>A review of the Comprehensive Plan of Care (CPOC) dated December 14, 2004, revealed the antibiotic use was not added to the CPOC. The CPOC was not reviewed/revised to include intervention of the Cipro and Mucinex/Guaifenesin as ordered for sinusitis.</p> <p>Interview on October 28, 2010, at 11:30 a.m., with the Minimum Data Set (MDS) Coordinator, who was responsible for updating the CPOCs, revealed the CPOC should have been updated to reflect the antibiotic usage.</p> <p>4. Review of resident #6's medical record revealed resident #6 was admitted to the facility on September 2, 2010, with a diagnosis of Anxiety state, Depression, Hypertension, and Cerebrovascular Accident with right-sided weakness and joint pain.</p> <p>Observation on October 26, 2010, at 11:45 a.m., revealed resident #6 was in the bed with half side rails elevated.</p> <p>Review of physician's orders for October 2010 revealed resident #6 had an order for half side rails up at all times for bed mobility. Further</p>	F 280			

PRINTED: 11/24/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/28/2010
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 280	<p>Continued From page 16</p> <p>resident #8 was wearing non-skid soles. Further interventions were to provide a wander guard device for resident #8.</p> <p>Review of the nurse's notes dated October 23, 2010, at 4:15 p.m., revealed resident #8 sustained a fall while visiting another resident. No injury was sustained. Further review revealed the care plan had not been revised to address resident #8's fall.</p> <p>Interview on October 28, 2010, at 11:30 a.m., with the MDS Coordinator revealed the MDS Coordinator was hired approximately two months ago. The MDS Coordinator stated care plans were updated each morning from the physician's order of the previous day.</p> <p>The MDS Coordinator was not familiar with the Admission Care Plan and had not seen the form before. The MDS Coordinator stated the Admission Care Plans were not updated because new care plans were generated, but the fall would be addressed when the Admission MDS was completed.</p>	F 280		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to follow physician's orders for one (1) of sixteen (16) sampled residents (resident #13). Resident #13 had orders for Tramadol 50 milligrams (mg)</p>	F 281	<p>West Liberty Nursing and Rehabilitation strives to ensure that services provided or arranged by facility meet professional standards of quality.</p> <p>The physician and family were notified of the medication error for resident #13 on 10-28-10 by LPN. No additional orders were received but the nursing staff did monitor. The nurse involved in the incident received one-on-one education by the DON on 11-4-10 regarding the five rights of medication administration.</p>	12/03/10

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

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 10/28/2010	
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 281	<p>Continued From page 17</p> <p>three (3) times daily, and Ativan 0.5 mg twice a day. Tramadol 50 mg was not administered at the noon dose, and Ativan 0.5 mg was administered instead. In addition, fifty-nine (59) hemocult cards and four (4) blood culture vacutainers were expired and available for use.</p> <p>The findings include:</p> <p>A review of resident #13 physician's orders revealed Tramadol 50 mg was to be given three times daily, and Ativan 0.5 mg to be given twice daily.</p> <p>During observation of the narcotic count on October 28, 2010, at 11:00 a.m., it was discovered that resident #13 had one extra Tramadol 50 mg tablet, and was missing one Ativan 0.5 mg tablet.</p> <p>Review of the Medication Administration Record (MAR) revealed Tramadol 50 mg tablet to be given every six hours at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m. Further review revealed Ativan 0.5 mg twice daily at 8:00 a.m. and 8:00 p.m.</p> <p>An interview with the medication nurse on October 28, 2010, at 11:00 a.m., revealed Ativan 0.5 mg was given at noon instead of the Tramadol 50 mg as ordered. The medication nurse said distractions caused the medication error. The medication nurse said that the physician, pharmacist, and the family were notified of the error, and no new orders were received; however, resident #13's vital signs were being monitored.</p> <p>Additionally, during observation of the medication</p>	F 281	<p>All outdated hemocult cards and blood culture vacutainers were discarded by Charge Nurse on 10-28-10.</p> <p>The DON and L.P.N. reconciled the narcotic drawers on 10-28-10 to ensure that all other narcotic counts were accurate.</p> <p>An audit was conducted by Director of Nursing on 10-28-10 to ensure that all products in the medication cart, medication room and central storage supply areas were not expired.</p> <p>All nursing staff received additional education related to the expectations of providing or arranging for care that meet Professional Standards of Quality. Special emphasis was placed on medication administration and importance of checking for expired medical supplies on a daily basis.</p> <p>The DON/designee will observe medication pass on at least five residents per week on various shifts to ensure that the five rights of medication pass are being observed.</p> <p>The DON/designee will monitor storage areas for medical supplies at least once a week for four weeks to determine that supplies are removed from circulation prior to expiration date recorded on container.</p> <p>The results of these audits will be forwarded to the weekly Focus meeting. Additionally, the results will be forwarded to the monthly CQI meeting for further monitoring and continued compliance.</p>	

PRINTED: 11/24/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/28/2010
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 281	Continued From page 18 room on October 28, 2010, at 11:00 a.m., 59 hemocult cards had an expiration date of February 2008, and the developer expired January 2009, and remained available for resident use. In addition, four blood culture vacutainers had an expiration date of May 31, 2010, and available for use. An interview with the medication nurse on October 28, 2010, at 11:00 a.m., revealed the nurses were responsible for making sure the vacutainer and lab supplies were not expired.	F 281		
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, and review of the Resident Census and Conditions form, it was determined the facility failed to provide adequate supervision, and monitoring to prevent accidents for three (3) of sixteen (16) sampled residents (residents #2, #3, and #16). Resident #2 sustained three fractured toes while being weighed in a mechanical lift. In addition, chemicals were observed in unlocked/unsecured cabinets in the shower room, and at residents #3 and #16's bedside. The findings include:	F 323	West Liberty Nursing and Rehabilitation strives to ensure that the resident environment remains as free of accident hazards as is possible and residents receive adequate supervision and assistance devices to prevent accidents. The physician and family for resident number 2 were notified of the incident on 10-26-10 at 3:40 pm by L.P.N. The facility received orders from the physician for an x-ray on 10/25/10 and for a consult by an outside specialist on 10/26/10. The consult was scheduled for 10/29/10. Though the resident had PRN medication ordered, which was effective, the charge nurse obtained orders from the physician on 10-27-10 regarding scheduled pain medications for 48 hours. The resident visited an outside specialist on 10-29-10 and his written report indicates that there was no fracture. The report indicates that the resident has severe osteoporosis and some arthritis but had no clinical signs of a fracture and the x-rays obtained in his office did not support a	12/03/10

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

PRINTED: 11/24/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/28/2010
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 F 323	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 323	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Continued From page 19</p> <p>1. Review of resident #2's medical record revealed diagnoses which included Chronic Obstructive Pulmonary Disease, Hypertension, Coronary Artery Disease, Depression, Osteoporosis, B-Complex Deficit Anemia, Asthma, Esophageal Reflux, Arterial Sclerotic Vascular Disease, and Congestive Heart Failure. The quarterly Minimum Data Set (MDS) assessment dated July 14, 2010, revealed resident #2 required two staff for safe transfers and was required to be lifted by mechanical lift.</p> <p>Observation of resident #2's right foot on October 27, 2010, at 1:00 p.m., revealed no discoloration or swelling to the right foot. Resident #2 was wearing heel protectors. The resident complained of pain upon moving the right foot and the facility nurse was notified by the CNA. Tylenol 500 mg was administered by the medication nurse at 1:10 p.m. Observation at 3:00 p.m., revealed resident #2 was sleeping.</p> <p>A review of the Resident Visitor Incident Reporting policy/procedure dated April 1, 2007, revealed facility staff was required to report any resident incident immediately to nursing staff.</p> <p>Interview with CNAs #1, #2, and #3 on October 27, 2010, from 1:20 p.m. until 3:45 p.m., revealed on October 25, 2010, at 10:25 a.m., the CNAs weighed resident #2 using a mechanical lift. The CNAs stated when resident #2 was being returned to bed the resident's foot hit the bed and the resident complained of pain. Interviews with CNAs #1, #2, and #3 revealed each CNA thought one of the other CNAs had reported the incident. None of the CNAs reported the incident to nursing staff.</p>		<p>fracture. He also reviewed the films that were interpreted at Appalachian Regional Hospital on October 25, 2010. He could not appreciate any fractures on that film.</p> <p>The peroxide was removed from the bedside table by the DON on 10/28/10 when the surveyor brought it to the DON's attention.</p> <p>The T-gel shampoo was removed from the bedside table by the DON on 10/28/10 when the surveyor brought it to the DON's attention.</p> <p>The two cabinets in the shower room were cleared of all items by the charge nurse on 10-28-10. The cabinets were repaired by Maintenance Director on 10-28-10.</p> <p>The basket was removed by Charge Nurse on 10-28-10.</p> <p>The hair dryer, curling iron and razors were removed on 10-28-10 by Charge Nurse.</p> <p>The Virex was removed on 10-28-10 by Charge Nurse.</p> <p>The unsecured cabinet in the men's shower room was secured by Charge Nurse on 10-28-10.</p> <p>The process for preventing, monitoring and reporting accidents/hazards was reviewed by the Administrator and DON on 10-28-10. No changes were made to this process.</p>	

PRINTED: 11/24/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/28/2010
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 323	Continued From page 20 Review of the nursing notes for October 25, 2010, at 3:40 p.m., revealed resident #2 complained of pain in the right foot. The resident told the nurse while the CNAs were getting the resident's weight that the resident's right foot hit the bed frame. According to the nursing note the resident stated, "It's broke, I heard it crack." The nurse's note reflected the physician and responsible party were notified of the complaint and orders were received to obtain an x-ray of the right foot. The nursing notes dated October 26, 2010, at 6:00 p.m., indicated the results of the right foot x-ray were received. The physician was notified and orders received for an orthopedic consult. A review of the x-ray obtained on October 25, 2010, revealed: Arthritis in the ankle joint and tarsal bones; a fracture through the base of the proximal phalanx of the fourth toe, third toe and probably fifth toe, and also a hairline fracture through the base of the fifth metatarsal. An impression was included from the Radiologist including multiple fractures involving the toes which are non-displaced. Severe Osteoporosis. Interview with Licensed Practical Nurse (LPN) #1 on October 27, 2010, at 1:50 p.m., revealed no incident regarding resident #2 was reported on the first shift on October 25, 2010. Interview with LPN #2 on October 27, 2010, at 4:20 p.m., revealed on October 25, 2010, at 3:40 p.m., resident #2 complained of pain in the right foot and reported CNAs hit the resident's right foot on the bed while he/she was being weighed. LPN #2 stated the physician was contacted and orders were received to obtain an x-ray of the right foot. LPN #2 contacted resident #2's family and Emergency Medical Services (EMS) and	F 323	LPN charge nurses completed a body audit of all residents by 10-29-10 to determine that any injuries had been reported timely. Additionally, each interviewable resident was questioned by LPN charge nurses on 10-29-10 to determine that any injury or incident had been reported and recorded appropriately. The nursing staff observations and/or interviews revealed no further incidents/injuries that had not been previously reported. An environmental audit was conducted on 11-15-10 by Charge Nurse to ensure that all medical products were stored safely and could not be accessed by residents. The SRNA's involved in the incident regarding resident #2 received disciplinary actions by D.O.N. on 10-28-10 and 10-29-10. Additionally, these SRNA's received one-on-one education by D.O.N. on 10-28-10 and 10-29-10 regarding the appropriate facility reporting procedures. The maintenance director received additional education by the Administrator on 11-19-10 regarding the importance of thorough daily compliance rounds and timely repair to equipment. Each staff member received additional education related to the importance of ensuring that the resident environment remains as free of accident hazards as is possible; and that each resident receives adequate supervision and assistive devices	

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

PRINTED: 11/24/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/28/2010
--	--	--	--

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 323	<p>Continued From page 21</p> <p>resident #2 went for an x-ray of the right foot. LPN #2 stated a Tylenol ES 500 mg was given for complaint of pain at 4:00 p.m., and the resident did not complain of any further pain. LPN #2 stated an incident report was started.</p> <p>An interview with the Director of Nursing (DON) on October 28, 2010, at 1:45 p.m., revealed the investigation of the incident that occurred on October 25, 2010, with resident #2 determined CNAs #1, #2, and #3 did not report the incident immediately, and the CNAs have received disciplinary action of a one-day suspension.</p> <p>A review of in-service training related to use of lifts, dated February 17, 2010, revealed CNAs #1, #2, and #3 received training for the lifts utilized by the facility and had demonstrated proper techniques in how to utilize the lifts.</p> <p>An observation of the Sabrina lift on October 28, 2010, at 2:10 p.m., revealed facility staff utilized the lifts appropriately and the lift was in good working order.</p> <p>2. Observation during initial tour on October 26, 2010, at 11:20 a.m., revealed a partially used bottle of hydrogen peroxide sitting on resident #3's bedside table and a bottle of T-Gel shampoo on the bedside table of resident #16.</p> <p>Further observation during the General Observation/Environmental tour on October 27, 2010, at 1:15 p.m., revealed two unlocked/unsecured floor cabinets in the women's shower room. Further observation revealed a small basket in the cabinet on the right of the sink that contained: one disposable razor, a four-ounce partially used bottle of Sebex</p>	F 323	<p>to prevent accidents. Special emphasis was placed on chemical storage and timely reporting of accidents and incidents that occur.</p> <p>The DON/designee will do five random body audits and/or resident interviews each week for four weeks to determine if resident accidents/incidents are being reported appropriately.</p> <p>The Administrator/designee will monitor daily (Monday-Friday) via daily compliance rounds that chemicals and/or medical products are stored appropriately and that resident access is prohibited.</p> <p>The Administrator and DON will monitor daily (Monday-Friday) via compliance rounds that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistive devices to prevent accidents.</p> <p>The results of these audits will be forwarded to the weekly Focus meeting. Additionally, the results will be forwarded to the monthly CQI meeting for further monitoring and continued compliance.</p>	
-------	--	-------	--	--

PRINTED: 11/24/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/28/2010
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 323	<p>Continued From page 22</p> <p>Medicated Shampoo, two containers of Dawn Mist shaying cream, and a partially used bottle of Selenium Sulfide-a pharmacy dispensed lotion which listed a resident's name and the instructions for use. Further observation revealed a hair dryer, a curling iron and two opened packs of disposable razors containing four razors each lying on the floor of the cabinet.</p> <p>Observation of the cabinet to the left of the sink revealed the cabinet contained a partially used 946-milliliter spray bottle of Virex Tb (an industrial/institutional disinfectant). Further observation revealed the door to the women's shower room was ajar.</p> <p>Observation of the men's shower room revealed an unsecured cabinet that contained: three 11-ounce cans of Gentle Plus Shaving Cream, two 11-ounce cans of Dawn Mist Shaving Cream, one 9-ounce bottle of 4-in-1 body cleanser, two 8-ounce bottles of Fresh Moment Rinse Free Shampoo, a 16-ounce partially used bottle of Hydrogen Peroxide, a 3-ounce bottle of Afta by Mennen aftershave, and a spray can of White Rain Hair Spray.</p> <p>Interview on October 27, 2010, at 1:45 p.m., with CNAs #5 and #6 (bath aides) revealed the cabinets should be locked at all times and it was the responsibility of the bath aides to ensure the cabinets were locked at all times. CNA #5 revealed the observed items could be harmful to a resident and if spilled may cause a resident to fall. CNA #6 stated the CNA had failed to ensure the doors were locked. According to CNA #6, the Virex would be extremely harmful to residents if swallowed. Both CNAs stated residents were not permitted to keep chemicals, cleaning supplies,</p>	F 323		

PRINTED: 11/24/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/28/2010
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 323	<p>Continued From page 23 or medicines at the bedside.</p> <p>Interview on October 27, 2010, at 3:50 p.m., with the Director of Nursing (DON) revealed the bath aides were responsible to ensure the cabinets in the shower rooms were locked at all times and chemicals such as hydrogen peroxide and medicated shampoo should not be left at the resident's bedside. The DON stated the items found unsecured could be harmful to residents if swallowed.</p> <p>Review of the facility's Chemical Storage policy (not dated) revealed chemicals would be locked in a secured area.</p> <p>Review of the Resident Census and Condition dated October 26, 2010, revealed the facility had 16 residents with Dementia. Further review revealed the facility provided a list of 15 residents who had been assessed as exhibiting wandering behavior. On October 27, 2010, at 9:30 a.m., the DON stated three of the 15 residents constantly wandered in and out of rooms.</p> <p>Review of the Material Safety Data Sheet revealed the recommended first aid measures, precautions, and health hazard data for the following hazardous products:</p> <p>Virex: Eyes: May be moderately irritating to eyes. Skin: May be moderately irritating to skin. Ingestion: May be irritating to mouth, throat, and stomach. Inhalation: May cause irritation to the nose, throat, and respiratory tract.</p> <p>Hydrogen Peroxide:</p>	F 323	

PRINTED: 11/24/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/28/2010
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 323	Continued From page 24 Eyes: Corrosive to eyes. May cause irreversible tissue damage to the eyes including blindness. Skin: May cause skin irritation. Ingestion: Corrosive to throat. Inhalation: Corrosive to nose and lungs. 4-in-1 Body Cleanser: Eyes: Irritating to eyes. Seek medical attention if irritation persists. Ingestion: Contact Poison Control Center immediately. Selenium Sulfide Lotion: Eyes: Seek medical attention. Immediately flush eyes with water for several minutes. Inhalation: Remove to fresh air. Seek medical attention for any breathing difficulty. Skin: Avoid prolonged contact. Remove any contaminated clothing. Wash affected area with soap and large amounts of water. Afta Shave Lotion: Eyes: May cause eye irritation on direct contact. Skin: May cause skin irritation. Ingestion: May be harmful if swallowed. Inhalation: Overexposure may cause respiratory tract irritation.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents were free of significant	F 333	West Liberty Nursing and Rehabilitation strives to ensure that residents are free of any significant medication errors. The physician and family were notified of the medication error for resident #13 on 10-28-10 by LPN. No additional orders were received but the nursing staff did monitor. The nurse involved in the incident received one-on-one education by the DON on 11-4-10 regarding the five rights of	12/03/10

PRINTED: 11/24/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/28/2010
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 333	<p>Continued From page 25</p> <p>medication errors for one (1) of sixteen (16) sampled residents (resident #13). It was determined on October 28, 2010, during a controlled substance/narcotic count that resident #13 failed to receive an ordered dose of Tramadol 50 mg and received Ativan 0.5 mg instead.</p> <p>The findings include:</p> <p>Observation of the medication room on October 28, 2010, revealed the controlled substance/narcotic count to be inaccurate for two narcotics for resident #13. Ativan 0.5 mg was missing one tablet, and the Tramadol 50 mg had one additional tablet.</p> <p>An interview with the medication nurse on October 28, 2010, at 11:00 a.m., revealed resident #13 should have received a Tramadol 50 mg tablet at the last medication pass. According to the nurse, the resident received Ativan 0.5 mg instead of the ordered Tramadol. The nurse stated a medication error form was to be filled out and the physician notified of the medication error. The medication nurse stated the medication pass had been interrupted, and resident #13's medications had been administered incorrectly.</p> <p>Review of the medication error report on October 28, 2010, revealed the physician was contacted about the medication error for resident #13 with no new orders given except to monitor resident #13's vital signs.</p> <p>An interview with the Director of Nursing (DON) on October 28, 2010, at 2:30 p.m., revealed the physician, pharmacy, and family were contacted about the medication error. The DON further</p>	F 333	<p>medication administration.</p> <p>The DON and LPN reconciled the narcotic drawers on 10-28-10 to ensure that all other narcotic counts were accurate and medications had been administered as ordered.</p> <p>All nursing staff received additional education by DON on 11-19-10 regarding the importance of residents remaining free of significant drug errors. The five rights of medication administration were reviewed in addition to basic medication administration techniques.</p> <p>The DON/designee will observe medication pass on at least five residents per week on various shifts to ensure that appropriate medication techniques are utilized and that the five rights of medication administration are being observed.</p> <p>The results of these audits will be forwarded to the weekly Focus meeting. Additionally, the results will be forwarded to the monthly CQI meeting for further monitoring and continued compliance.</p>

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

PRINTED: 11/24/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/26/2010
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)	(X4) COMPLETION DATE
F 333	Continued From page 26	F 333		
F 364 SS=D	<p>stated resident #13 was being monitored with no side effects noticed from the medication error.</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure each resident received food that was palatable and at the proper temperature during the evening meal on October 26, 2010.</p> <p>The findings include:</p> <p>Observation on October 26, 2010, at 5:44 p.m., revealed CNAs were delivering trays from a food cart when the second cart arrived. The CNAs were not finished delivering the first set of trays. Three CNAs were observed delivering trays on the floor and one CNA was observed in the restorative dining room. Further observation revealed the last tray was delivered at 6:07 p.m. The Dietary Manager (DM) was contacted and temperatures were obtained by the DM as follows: Chicken nuggets were served at 104.3 degrees Fahrenheit, French fries were served at 101.7 degrees Fahrenheit, and coffee was served at 128.1 degrees Fahrenheit. A taste test revealed the chicken nuggets to be cool to taste, and the French fries were cold to touch and taste.</p>	F 364	<p>West Liberty Nursing and Rehabilitation strives to ensure each resident receives and facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>The resident tray reviewed by the surveyor was replaced by the Dietary Manager on 10/26/10.</p> <p>A review of the cart revealed two remaining plates. Those trays were also replaced by the Dietary Manager on 10/26/10.</p> <p>The process for dietary meal service was reviewed and revised by the Administrator, DON and Dietary Manager on 11-8-10. The improved process allows an extra staff member to be available on the floor for meal service and addresses emergency situations when the elevator cannot be utilized.</p> <p>All nursing staff received education regarding the updated process by DON on 11-8-10. All dietary staff received education regarding the updated process by Dietary Manager on 11-8-10.</p> <p>The dietary manager will audit food temps on random shifts at least two times per week for the next four weeks. Additionally, the Administrator/designee will attend resident council meetings monthly for the next three months to ensure that residents are satisfied</p>	12/03/10

PRINTED: 11/24/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/28/2010
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 364	<p>Continued From page 27</p> <p>An interview with the DM on October 26, 2010, at 6:07 p.m., revealed the point of service temperatures for hot foods should be served at or above 135 degrees Fahrenheit, and cold foods should be at or below 41 degrees Fahrenheit. The DM stated the food trays should not be left on the floor longer than 20-25 minutes to prevent foods from being served cold. The DM explained that random audits of meal services were performed by the DM during the month for all three meal services.</p> <p>An interview with the CNAs passing the meal trays during the evening meal on October 26, 2010, revealed none of the CNAs knew how long a meal tray should be left on the floor before it should be exchanged for a new tray.</p> <p>A review of the facility policy for Delivery and Return of Trays (undated) revealed, "Trays will be distributed to the residents by nursing personnel promptly." Further review of the Suggestions for Improving Tray Appearance policy (undated) revealed the facility was to "Have hot food hot and cold food cold when the tray reaches the resident."</p> <p>An interview with the Director of Nursing (DON) on October 26, 2010, at 6:30 p.m., revealed the CNAs were instructed to feed all residents on the floor, and not take residents to the main dining room on the first floor, related to adverse weather conditions, and the possible loss of electricity, with the elevator being unavailable if the facility lost power. The DON stated one CNA was to stay in the restorative dining room while the remaining CNAs passed the residents' trays in the resident rooms. The DON was unsure of the length of time a meal tray could remain on the</p>	F 364	<p>with meal service and meal temperatures.</p> <p>The results of these audits will be forwarded to the weekly Focus meetings. Additionally, this information will be forwarded to the monthly CQI committee meeting for further monitoring and continued compliance.</p>	

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

PRINTED: 11/24/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/28/2010
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 364	Continued From page 28 floor before being served to a resident. The DON stated a new tray could be ordered if a CNA felt the tray had been on the tray cart too long.	F 364		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure garbage and refuse was disposed of properly. The facility dumpster was observed to be uncovered with garbage bags exposed on October 28, 2010. The findings include: Observation of the dumpster area on October 28, 2010, at 10:00 a.m., revealed the lid to the dumpster was completely off and leaning on the inside of the fence that surrounded the dumpster. An interview with the Dietary Manager (DM) on October 28, 2010, at 11:00 a.m., revealed the DM did not know when/why the lid had been removed. An interview with the Maintenance Supervisor (MS) on October 28, 2010, at 2:20 p.m., revealed the garbage truck had emptied the dumpster and broken off the lid. The MS stated staff had laid the lid on the inside of the fence on Monday, October 25, 2010. The MS explained the lid was too heavy to put back into the truck and the garbage company would be called to replace the dumpster. The MS was aware the dumpster should not be left with the lid removed.	F 372	West Liberty Nursing and Rehabilitation strives to dispose of garbage and refuse properly. The dumpster lid was replaced by waste management company on 10-29-10. There are no other dumpsters on site. The maintenance director received additional education by Administrator on 11-19-10 regarding the importance of proper disposal of garbage and refuse. All staff received additional education by Administrator on 11-19-10 and 11-22-10 regarding the importance of reporting any problems to a supervisor when there is a problem with the dumpster. The administrator will observe the dumpster at least once a week for the next four weeks to ensure that there are no problems noted with the operation of the dumpster. The results of these audits will be forwarded to the weekly Focus meetings. Additionally, this information will be forwarded to the monthly CQI committee meeting for further monitoring and continued compliance.	12/03/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 11/24/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/28/2010
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 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 direct contact will transmit the disease. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	West Liberty Nursing and Rehabilitation 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. The wound for resident #3 was re-dressed by Wound Care Nurse on 11-3-10. No signs or symptoms of infection were present. Resident #3 was assessed by Wound Care Nurse on 11-3-10. No signs or symptoms of infection were noted. The DON reviewed the facility infection control protocols on 10-29-10. No changes were made to the policies. The Wound Care Nurse received one-on-one education by the DON on 11-9-10 regarding the appropriate protocols for changing a dressing to a wound. Employee #3 received one-on-one education regarding appropriate catheter care on 11-10-10. The DON reviewed the Infection Control Logs for the last 90 days. No trends could be identified related to improper wound care or catheter care. All nursing staff received additional education on 11-19-10 and 11-22-10 by DON regarding the importance of maintaining an infection control program.	12/03/10

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

PRINTED: 11/24/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/28/2010
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 30</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined that the facility failed to maintain an effective Infection Control Program designed to provide a safe, sanitary environment to prevent the development/transmission of disease and infection. During the provision of wound care for resident #3, the wound care nurse failed to utilize acceptable handwashing technique/infection control practices. Additionally, CNA #3 failed to follow acceptable infection control practices and facility policy during the provision of catheter care for resident #3.</p> <p>The findings include:</p> <p>1. A review of the medical record for resident #3 revealed the October 2010 monthly physician's orders instructed staff to provide daily wound care to a nonstageable pressure area on resident #3's coccyx.</p> <p>During treatment observation on October 27, 2010, at 9:40 a.m., the wound care nurse was observed to remove a soiled dressing from resident #3. The wound care nurse removed the soiled gloves and donned clean gloves; however, the wound care nurse failed to wash/sanitize hands prior to donning the clean gloves. The wound care nurse proceeded with the wound treatment, cleansed the wound with Saf-Cleans AF spray, then packed the wound with Santyl and covered the wound with an Allewyn dressing. Further observation revealed the wound care nurse then performed a complete skin assessment for resident #3. The wound care nurse continued to wear the gloves worn during</p>	F 441	<p>designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>The DON/designee will observe at least three dressing changes per week on various shifts for four weeks to ensure that facility protocols are followed. She will also observe at least three episodes of catheter care per week on various shifts for four weeks to ensure that facility protocols are followed. Additionally, DON/designee will monitor, via daily (Monday-Friday) compliance rounds, general infection control procedures (such as handwashing, linen handling, peri-care, etc.) to ensure that all aspects of the facilities infection control procedures are implemented as directed. Any violation will immediately be addressed.</p> <p>The results of these audits will be forwarded to the weekly Focus meeting. Additionally, these results will be forwarded to the monthly CQI committee meeting for further monitoring and continued compliance.</p>		

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

 PRINTED: 11/24/2010
 FORM APPROVED
 OMB NO. 0938-0391

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 10/28/2010
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 31</p> <p>the wound care to perform the skin assessment. The wound care nurse touched resident #3's skin, gown, and bed linens with the same gloves.</p> <p>Interview on October 27, 2010, at 5:20 p.m., with the wound care nurse revealed the nurse was knowledgeable of current infection control policies. The wound care nurse stated he/she failed to wash/sanitize hands after removing gloves. The wound care nurse stated gloves should have been removed after the wound care, hands should have been washed/sanitized, and clean gloves applied to perform the skin assessment.</p> <p>Review of the facility policy titled Handwashing and Hand Hygiene dated August 1, 2003, revealed handwashing was recognized as the most basic, yet most effective means of preventing the spread of infection. Further review of the policy directed staff to wash/sanitize hands before and after handling dressings or touching open wounds and after touching excretions (feces, urine, or material soiled with them) or secretions (from wounds, skin infections, etc.).</p> <p>2. Review of the facility policy/procedure for Female Catheter Care dated September 1997 revealed the following steps: Explain the procedure to the resident and provide privacy. Prepare warm water, use small amount of soap on wash cloth. Use non-dominant hand to open labia to expose urethra, labia is to remain open until rinsed. Use dominant hand to wipe around catheter at insertion site using circular movements. Turn wash cloth and wipe down one side of the labia and then wipe the other side. Keeping the labia open, rinse wash cloth in clean water. Rinse using same technique then use</p>	F 441			

PRINTED: 11/24/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/28/2010
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	Continued From page 32 towel to dry the labia. Observation on October 27, 2010, at 10:10 a.m., revealed CNA #3 performed indwelling catheter care for resident #3. CNA #3 used a moistened wash cloth from a pan of water with peri-wash added. The CNA held the labia open with the left hand and cleansed the labia on both sides in a downward motion. The CNA then cleansed the meatus and catheter tubing, cleansing away from the urethra. The CNA released the labia, placed the wash cloth in the pan of water, obtained a clean wash cloth, and put the clean wash cloth in the water with the previous used wash cloth. The CNA used the second cloth to repeat the procedure. The CNA stated the procedure was complete and emptied the water, removed gloves, and washed/sanitized hands. Interview on October 27, 2010, at 10:25 a.m., with CNA #3 revealed the CNA thought he/she should not have placed the soiled washcloth in the water with the clean washcloth. The CNA was unaware of the facility policy related to catheter care.	F 441	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain accessible/fully functional call light systems in residents' rooms and in the shower rooms.	F 463	West Liberty Nursing and Rehabilitation strives to maintain a nurses station that is equipped to receive resident's calls through a communication system from resident room, toilet and bathing facilities. The pull cord on the emergency light in both women's shower rooms were replaced by Maintenance Supervisor on 10-27-10. The pull cord in resident room 17 and 51 was replaced by Maintenance Supervisor on 10-27-10.

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

PRINTED: 11/24/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/28/2010
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 463	Continued From page 33 The findings include: Observations during the environmental tour on October 27, 2010, at 1:05 p.m., revealed one of the three emergency call lights in the women's shower room did not have a pull cord attached. Observation of the shower room located on the newer addition revealed one of the four emergency call lights did not have a pull cord attached. Continued observation of resident rooms/bathrooms revealed the pull cord of the call light in the bathroom of resident room 17 was approximately seven inches with frayed edges. The call bell in resident room 44 would not activate when the button was pushed. Further observation revealed the pull cord was missing from resident room 51, bed 2. The end plug was in the wall plate but the pull cord had been removed. Interview on October 27, 2010, at 1:20 p.m., with the Maintenance Supervisor (MS) revealed the CNAs reported problems with the call system. The MS stated the MS made rounds each morning but did not routinely check the call bell system. The MS explained a new cord was needed in resident room 44 and the resident in room 51, bed 2 had previously pulled the cord so hard that the cord separated from the plug. The MS thought this had occurred again.	F 463	The call bell in room 44 was repaired by Maintenance Supervisor on 10-27-10. An audit of all call bell cords and call light activation was conducted by the Maintenance Supervisor on 10-28-10 to ensure that pull cords and call bells were in good working order and that call bell activation was functioning in all resident rooms and shower rooms. The Administrator and maintenance director reviewed preventive maintenance policies on 10-28-10. No changes were made to these policies. The maintenance director received additional education by the Administrator on 11-19-10 regarding the importance of ensuring that each nurse station is equipped to receive resident calls through a communication system and that call equipment is fully functioning in all resident rooms and shower rooms. The Administrator/designee will monitor pull cords, call bells and functioning status of the call bell system via daily (Monday-Friday) compliance rounds for four weeks. The results will be forwarded to the weekly Focus meeting. Additionally, the results will be reviewed at the monthly CQI meeting for further monitoring and continued compliance.	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465	West Liberty Nursing and Rehabilitation strives to provide a safe, functional, sanitary	12/03/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 11/24/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/28/2010	
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 465	<p>Continued From page 34 residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Scraped and chipped drywall was observed in six (6) resident rooms/bathrooms, the ceiling was soiled in two (2) resident rooms, floor tiles were chipped, formica was chipped on sinks in two (2) resident rooms, rolling bedside tables and entry doors were chipped exposing splintered wood, and two (2) privacy curtains were soiled.</p> <p>The findings include:</p> <p>During the environmental tour of the facility on October 27, 2010, at 1:05 p.m., the following items were observed to be in need of repair:</p> <ul style="list-style-type: none"> -The floor tiles were cracked in front of the women's shower room, in the hallway in front of the elevator, and at the emergency fire doors threshold near the nurses' station. -The drywall was observed to be chipped/peeling in resident rooms 30, 41, 45, 51 and in bathrooms in rooms 31 and 32. -Drill holes were observed in the walls of resident rooms 44, 45, 46, and 51. -A large hole was observed in the wall behind the door of resident room 46 and in the women's shower room. -Brown spots were observed on the ceiling of resident rooms 45 and 46. -The protective wall plate was loose at the head of the bed in resident room 46. 	F 465	<p>and comfortable environment for residents, staff and the public.</p> <p>The drywall was repaired by the Maintenance Supervisor on 11-3-10.</p> <p>The cracked floor tiles were replaced by the Maintenance Supervisor on 11-1-10.</p> <p>The drill holes were repaired by the Maintenance Supervisor on 11-3-10.</p> <p>The hole in room 46 and in the women's shower room was repaired by the Maintenance Supervisor on 11-3-10.</p> <p>The ceiling tiles were replaced in rooms 45 and 46 by the Maintenance Supervisor on 11-3-10.</p> <p>The protective wall plate in room 46 was secured by the Maintenance Supervisor on 11-3-10.</p> <p>The rolling bed tables in room 31 and 46 were replaced by Housekeeping Supervisor on 11-1-10.</p> <p>The exposed screws on the commode in room 32 were covered by the Maintenance Supervisor on 11-22-10.</p> <p>The sink tops in rooms 27 and 28 were measured and orders placed for new sink tops by the Maintenance Supervisor on 11-23-10.</p>	

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

PRINTED: 11/24/2010
FORM APPROVED
OMB NO. 0938-0391

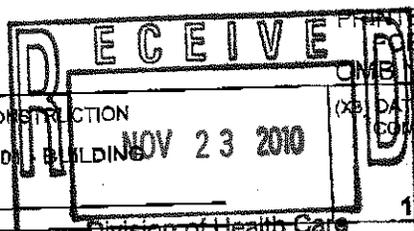
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/28/2010
--	--	--	--

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 465	<p>Continued From page 35</p> <ul style="list-style-type: none"> -The rolling bedside table in resident rooms 31 and 46 had rough, splintered, and chipped edges. -Large screws were exposed and protruding from the commode in resident room 32. -The formica was chipped at the sink in resident rooms 27 and 28. -The entry doors to resident rooms 25 and 26 were marred and exposed splintered wood. -The privacy curtains in resident rooms 17 and 45 were soiled with a brownish substance. <p>Interview on October 27, 2010, at 1:20 p.m., with the Maintenance Supervisor (MS) revealed the MS made rounds each morning to look for items in need of repair, especially anything that may be hazardous to residents. The MS revealed he/she was aware of the cracked floor tiles in the hallway and had replaced the tiles previously. The MS stated the drill holes in the walls in multiple rooms were from removing disposable glove containers. The new glove containers were installed in a different area and the MS had not repaired the walls. The MS revealed he/she was not aware of other items in need of repair.</p> <p>Interview on October 28, 2010, at 10:45 a.m., with the Housekeeping Supervisor (HS) revealed the housekeepers were to inspect privacy curtains every day and replace if visibly soiled. The HS stated staff must have overlooked the soiled privacy curtains.</p>	F 465	<p>The entry doors to resident rooms 25 and 26 were repaired by the Maintenance Supervisor on 11-1-10.</p> <p>The privacy curtains in rooms 17 and 45 were washed by Laundry staff on 10-27-10.</p> <p>The procedures for routine environmental audits were reviewed by the Administrator, Housekeeping Supervisor and maintenance director on 10-29-10. No changes were made to these procedures.</p> <p>An environmental audit was conducted by the Administrator, maintenance director and housekeeping supervisor on 11-12-10 to the facility maintained a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>The Administrator provided additional education to the maintenance director and housekeeping supervisor on 11-19-10 regarding the importance of maintaining a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>The Administrator/designee will monitor the environment via daily (Monday-Friday) compliance rounds to ensure that the facility environment is acceptable.</p> <p>The results will be forwarded to the weekly Focus meeting. Additionally, the results will be reviewed at the monthly CQI meeting for further monitoring and continued compliance.</p>	
-------	--	-------	--	--

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



PRINTED: 11/15/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/27/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER WEST LIBERTY NURSING & REHABILITATION CENTER	STREET ADDRESS 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
--------------------	--	---------------	---	----------------------

K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on October 27, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" 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.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain fire/smoke dampers that penetrated the fire/smoke barrier walls. This deficient practice affected four (4) of four (4) smoke compartments, staff, and 48 residents. The facility has the capacity for 50 beds with a census of 48 on the day of the survey. The findings include: During the Life Safety Code survey on October	K 025	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 Center strives to ensure that fire/smoke barriers are inspected and maintained in accordance with all NFPA codes. All fire/smoke barriers were scheduled 11-22-10 to be serviced by a certified HVCA contractor. This will be completed by 12-3-10. Maintenance Supervisor will monitor monthly for three months and quarterly thereafter. Results will be forwarded to the Safety Committee monthly to determine further compliance needed.	12/03/10

LABORATORY/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Janet J. Burt</i>	TITLE Administrator	(X8) DATE 11/23/10
---	------------------------	-----------------------

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.

PRINTED: 11/15/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2010
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
K 025	Continued From page 1 27, 2010, at 9:00 a.m., with the Director of Maintenance (DOM) a fire/smoke barrier wall above the fire doors on the first floor was observed to have ductwork that contained a fire/smoke damper. A fire/smoke damper closes to prevent fire and hot gases from penetrating the fire/smoke barrier wall and is required to be inspected and maintained every four years. An interview with the DOM on October 27, 2010, at 9:00 a.m., revealed the fire alarm company checks the dampers in the facility and advises the facility if there is anything wrong with the dampers. The DOM stated if there was a problem with the dampers the facility would have the dampers repaired by a heat/air company. The facility could not provide documentation that the dampers had been properly checked or maintained by NFPA requirements. Reference: NFPA 90a (1999 Edition). 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 025		
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of	K 051	West Liberty Nursing and Rehabilitation Center strives to ensure all fire alarm systems are in accordance to NFPA 72. Tests of all fire alarm pull station were activated and each zone was determined, labeled and a chart posted at the fire alarm panel for staff to reference by the Maintenance Supervisor on 11-22-10.	

PRINTED: 11/15/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 10/27/2010
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
K 051	<p>Continued From page 2</p> <p>nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, a test of the fire alarm system revealed staff was unable to determine where the fire zones were located throughout the facility. This deficient practice affected four (4) of four (4) smoke compartments, staff, and 48 residents. The facility has the capacity for 50 beds with a census of 48 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on October 27, 2010, at 11:20 a.m., with the Director of Maintenance (DOM) a test of a fire alarm pull station revealed the pull station was activated in zone 10 at the fire alarm panel. An interview with the DOM on October 27, 2010, at 11:20 a.m., revealed the DOM thought each pull station in the facility was a different zone. More testing</p>	K 051	<p>Maintenance Supervisor will monitor monthly during fire drills to assure effective zones are properly displayed according to the chart posted.</p> <p>Results will be forwarded to the Safety Committee monthly to determine further compliance needed.</p>	

PRINTED: 11/15/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2010
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
K 051	Continued From page 3 revealed zone 10 was one of two smoke compartments located on the second floor. There was not a chart located at the fire alarm panel for staff to reference in case the fire alarm system activated. After testing the fire alarm system the DOM acknowledged staff would have trouble locating different zones in the facility at the fire alarm panel. Reference: NFPA 72 (1999 Edition). 1-5.7.1.1 The primary purpose of fire alarm system annunciation is to enable responding personnel to identify the location of a fire quickly and accurately and to indicate the status of emergency equipment or fire safety functions that might affect the safety of occupants in a fire situation. All required annunciation means shall be readily accessible to responding personnel and shall be located as required by the authority having jurisdiction to facilitate an efficient response to the fire situation.	K 051		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076	West Liberty Nursing and Rehabilitation Center strives to ensure proper oxygen cylinder tanks are properly stored according to code. The combustible items were removed and cylinder tanks arranged to meet the footage requirements on 10-27-10 by the Maintenance Supervisor. Maintenance Supervisor will monitor daily (Monday - Friday) for four weeks to ensure compliance.	

PRINTED: 11/15/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING E. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2010
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
K 076	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that oxygen cylinders were stored according to NFPA standards. This deficient practice affected one (1) of four (4) smoke compartments, staff, and approximately eighteen (18) residents. The facility has the capacity for 50 beds with a census of 48 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on October 27, 2010, at 10:15 a.m., with the Director of Maintenance (DOM) oxygen cylinder tanks were observed to be stored within five feet of combustible storage in the oxygen storage room. Oxygen cylinders while in storage and in quantities greater than 300 cubic feet must be kept five feet from combustibles. An interview with the DOM on October 27, 2010, at 10:15 a.m., revealed the DOM had made staff aware of this requirement; however, the DOM stated staff would not adhere to this requirement. Quantities 300 cubic feet (12 E sized cylinders) and less may follow the requirements of S&C-07-10.</p> <p>Reference: S&C-07-10.</p> <p>Up to 300 cu ft (12 E sized cylinders) of nonflammable medical gas can be located outside of an enclosure (per smoke compartment) at locations open to the corridor such as at a nurse's station or in a corridor of a healthcare facility.</p> <p>This amount of nonflammable medical gas per smoke compartment is not considered a hazard if</p>	K 076	Results will be forwarded to the Safety Committee monthly to determine further compliance needed.

PRINTED: 11/15/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2010
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
--------------------	--	---------------	---	----------------------

K 076	<p>Continued From page 5</p> <p>the containers are properly secured, such as in a rack to prevent them from tipping over or being damaged. In this case the medical gas is considered an "operational supply" and not storage. If the cylinders are placed in a corridor they should be placed so as not to obstruct the use of the corridor. This amount of medical gas is in addition to those cylinders contained in "crash carts" and in use on wheelchairs or gurneys.</p> <p>The term "PRN" means "as needed." An individual cylinder placed in a patient room for immediate use by a patient is not required to be stored in an enclosure and is considered in use. It should be secured to prevent tipping or damage to the cylinder. If the resident does not need the use of oxygen for an extended period of time, such as several days, then the medical gas container should be removed from the room and properly secured in an approved storage room.</p> <p>Reference: NFPA 99 (1999 Edition). 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an</p>	K 076		
-------	--	-------	--	--

PRINTED: 11/15/2010
 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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2010
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
K 076	Continued From page 6 automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.	K 076		

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

PRINTED: 11/15/2010

FORM APPROVED
OMB NO. 0938-0391

R E C E I V E D

NOV 23 2010

10/27/2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2010
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WEST LIBERTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 774 LIBERTY ROAD, P O BOX 107 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 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on October 27, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" 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 alleged deficiencies. This plan of correction is prepared and /or executed solely because it is required by the provisions of Federal and State law.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain fire/smoke dampers that penetrated the fire/smoke barrier walls. This deficient practice affected four (4) of four (4) smoke compartments, staff, and 48 residents. The facility has the capacity for 50 beds with a census of 48 on the day of the survey. The findings include: During the Life Safety Code survey on October	K 025	West Liberty Nursing and Rehabilitation Center strives to ensure that fire/smoke barriers are inspected and maintained in accordance with all NFPA codes. All fire/smoke barriers were scheduled 11-22-10 to be serviced by a certified HVCA contractor. This will be completed by 12-3-10. Maintenance Supervisor will monitor monthly for three months and quarterly thereafter. Results will be forwarded to the Safety Committee monthly to determine further compliance needed.	12/03/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Camela J. Burt</i>	TITLE Administrator	(X6) DATE 11/23/10
--	-------------------------------	------------------------------

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: 11/15/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2010
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
K 025	Continued From page 1 27, 2010, at 9:00 a.m., with the Director of Maintenance (DOM) a fire/smoke barrier wall above the fire doors on the first floor was observed to have ductwork that contained a fire/smoke damper. A fire/smoke damper closes to prevent fire and hot gases from penetrating the fire/smoke barrier wall and is required to be inspected and maintained every four years. An interview with the DOM on October 27, 2010, at 9:00 a.m., revealed the fire alarm company checks the dampers in the facility and advises the facility if there is anything wrong with the dampers. The DOM stated if there was a problem with the dampers the facility would have the dampers repaired by a heat/air company. The facility could not provide documentation the dampers had been properly checked or maintained by NFPA requirements. Reference: NFPA 90a (1999 Edition). 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 025	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	West Liberty Nursing and Rehab Center strive to observe all life safety standards. Doors were adjusted to comply with the 15 second delay egress on 11-22-10 by the Maintenance Supervisor. Proper signage was posted on both doors 11-22-10.

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

PRINTED: 11/15/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 10/27/2010
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
K 038	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exit doors were readily accessible at all times and had the proper signage.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on October 27, 2010, at 9:30 a.m., with the Director of Maintenance (DOM) two exit doors with a magnetic locking device located on the first floor were observed not to have the proper signage indicating the doors would release in 15 seconds as required. An interview with the DOM on October 27, 2010, at 9:30 a.m., revealed the doors were locked at night and the coded key pad was the only way to release the locks. The DOM was unaware the doors would have to be accessible for exiting purposes, even at night.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not</p>	K 038	<p>Maintenance will monitor the doors weekly to ensure exit doors are readily accessible to the 15 second delay and that signage is posted properly.</p> <p>Results will be forwarded to the Safety Committee monthly to determine further compliance needs.</p>	

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

PRINTED: 11/15/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 10/27/2010
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	
K 038	Continued From page 3 more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.8. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 038			
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of	K 051	West Liberty Nursing and Rehabilitation Center strives to ensure all fire alarm systems are in accordance to NFPA 72. Tests of all fire alarm pull station were activated and each zone was determined, labeled and a chart posted at the fire alarm panel for staff to reference by the Maintenance Supervisor on 11-22-10. Maintenance Supervisor will monitor monthly during fire drills to assure effective	12/03/10	

PRINTED: 11/15/2010
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: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2010
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
K 051	Continued From page 4 power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and interview, at test of the fire alarm system revealed staff was unable to determine where the fire zones were located throughout the facility. This deficient practice affected four (4) of four (4) smoke compartments, staff, and 48 residents. The facility has the capacity for 50 beds with a census of 48 on the day of the survey. The findings include: During the Life Safety Code survey on October 27, 2010, at 11:20 a.m., with the Director of Maintenance (DOM) a test of a fire alarm pull station revealed the pull station was activated in zone 10 at the fire alarm panel. An interview with the DOM on October 27, 2010, at 11:20 a.m., revealed the DOM thought each pull station in the facility was a different zone. More testing revealed zone 10 was one of two smoke compartments located on the second floor. There was not a chart located at the fire alarm	K 051	zones are properly displayed according to the chart posted. Results will be forwarded to the Safety Committee monthly to determine further compliance needed.	

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

PRINTED: 11/15/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2010
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
K 051	Continued From page 5 panel for staff to reference in case the fire alarm system activated. After testing the fire alarm system the DOM acknowledged staff would have trouble locating different zones in the facility at the fire alarm panel. Reference: NFPA 72 (1999 Edition). 1-5.7.1.1 The primary purpose of fire alarm system annunciation is to enable responding personnel to identify the location of a fire quickly and accurately and to indicate the status of emergency equipment or fire safety functions that might affect the safety of occupants in a fire situation. All required annunciation means shall be readily accessible to responding personnel and shall be located as required by the authority having jurisdiction to facilitate an efficient response to the fire situation.	K 051		
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a gas furnace exhaust vent as required. This deficient practice affected one (1) of four (4) smoke compartments, staff, and the resident dining area. The findings include:	K 067	West Liberty Nursing and Rehabilitation Center strives to ensure all gas furnace exhaust vents are maintained properly according to code. The exhaust vent was replaced in the dining room mechanical closet on 11-3-10 by the Maintenance Supervisor. The Maintenance Supervisor inspected and maintains all exhaust on 11-3-10. Audits will be completed monthly to ensure exhaust vents are maintained properly. The results of these inspections will be submitted to the Safety Committee for review and potential follow up action.	12/03/10

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

PRINTED: 11/15/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2010
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
K 067	Continued From page 6 During the Life Safety Code tour on October 27, 2010, at 9:20 a.m., with the Director of Maintenance (DOM) observation revealed holes and cracks in the exhaust vent for a gas furnace located in the dining room closet. Vents for gas burning equipment need to be maintained to prevent unwanted vapors from reaching the room area. An interview with the DOM on October 27, 2010, at 9:20 a.m., revealed the DOM was unaware of the cracks and holes in the vent. Reference: NFPA 101 (2000 Edition). 9.2.2 Ventilating or Heat-Producing Equipment. Ventilating or heat-producing equipment shall be in accordance with NFPA 91, Standard for Exhaust Systems for Air Conveying of Vapors, Gases, Mists, and Noncombustible Particulate Solids Reference: NFPA 91 (1999 Edition). 7-1 General. Exhaust systems shall be tested, inspected, and maintained to ensure safe operating conditions.	K 067		