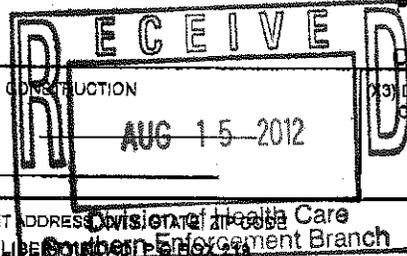


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 07/30/2012
FORM APPROVED
CME 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 C 07/16/2012
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NAME OF PROVIDER OR SUPPLIER WEST LIBERTY NURSING & REHABILITATION CENTER	STREET ADDRESS 774 LIBERTY BLDG WEST LIBERTY, KY 41472
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	Preparation and execution of this response and plan of correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiency/ies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the policy of West Liberty Nursing and Rehabilitation Center to inform the resident; consult with the resident's physician; and if known, notify the residents legal representative or interested family member when there is a need to alter resident's treatment significantly. The physician was notified by the MDSC of the altered treatment of removing the side rails on resident #1 on 7-16-12 and a clarification order received. All incident reports and daily nursing reports have been reviewed by the DON/ RN Supervisor for the last 60 days to determine that no altered treatment has occurred in which the resident's physician was not notified. All licensed staff received additional education by the DON concerning physician notification requirements regarding altered	8/15/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Damla Dutton* TITLE: Administrator (X6) DATE: 8-8-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Received Time Aug. 15, 2012 1:25PM No. 0162

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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 consult with the resident's physician for a need to alter treatment for one of three sampled residents. Resident #1 obtained a bruise to the left side of the resident's forehead which staff determined was from hitting his/her head on the side rail. The facility discontinued Resident #1's side rails on 06/28/12; however, the physician was not consulted when the resident's side rails were discontinued. The findings include: A review of the medical record for Resident #1 revealed the facility admitted the resident on 12/22/11, with diagnoses that included Hypertension, Fatigue, History of Falls, and Late Effect CVA (Cerebrovascular Accident or stroke). Interview with Licensed Practical Nurse (LPN) #2 on 07/16/12, at 5:17 PM, revealed the LPN was working the first shift on the day the bruise was discovered on Resident #1's forehead. The interview further revealed since it was unknown how the resident obtained the bruise, the resident's room was checked for hazards and it was determined by staff that the resident hit his/her head on the side rails. The LPN stated the side rails were removed the day the bruise was discovered, 06/28/12. A review of Resident #1's physician's orders revealed on 08/28/12, the physician was notified	F 157	treatment of residents by 7-20-12. Nursing administration will review the 24 hour nursing report and all incident reports for the next 60 days and follow-up to ensure that the physician is notified timely for change in resident's altered treatment plan. The results of the audit will be reviewed in the CQI Committee meeting for further monitoring and continued compliance.	

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F 157	Continued From page 2 of the bruise to Resident #1's forehead, but there was no evidence the physician was consulted, notified related to the resident's side rails being discontinued. Further interview with LPN #2 revealed it probably was his/her responsibility to call the doctor to obtain an order to discontinue the side rails, but since other staff was involved when the side rails were removed, he/she assumed the order had been obtained from the physician. Interview with the Director of Nursing (DON) on 07/16/12, at 3:05 PM, revealed Resident #1's side rails were removed on 06/28/12, because staff believed the resident had hit his/her head on the side rail causing the bruise. The DON stated it was the responsibility of the nurse working on the floor to contact the doctor for an order to discontinue Resident #1's side rails.	F 157		
F 280 SS=D	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, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280	It is the Policy of West Liberty Nursing and Rehabilitation Center to allow the residents 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. The care plan for Resident #1 and #2 was updated by the MDSC on 7-16-12 to reflect the current needs of each resident based on each resident's current status. An audit of all residents care plans will be completed by the Interdisciplinary Care Plan Team by 8-15-12 to ensure that the resident's care plan reflects the resident's current status.	8/15/12

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F 280	<p>Continued From page 3</p> <p>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 the facility failed to review/revise the plan of care for two of three sampled residents (Residents #1 and #2). The facility developed a care plan for Resident #1 with an intervention for two side rails to assist with bed mobility. Resident #1's side rails were discontinued on 06/28/12; however, the care plan was not revised. Resident #2 had a physician's order to have one-half side rails; however, the side rail use was not on the resident's care plan.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Observations on 07/16/12, of Resident #1 revealed the resident was not utilizing side rails on the resident's bed. <p>A review of Resident #1's physician orders dated July 2012 revealed the resident had utilized two one-half side rails for bed mobility. A review of Resident #1's care plan dated 12/22/11, revealed the facility developed a care plan for two one-half side rails raised when in bed for bed mobility.</p> <p>However, further review of Resident #1's physician orders revealed the side rails were discontinued on 07/16/12. There was no evidence the resident's care plan was revised to</p>	F 280	<p>The Interdisciplinary Care Plan Team will received additional education by the DON by 8-6-12 regarding the need to update care plans when required.</p> <p>The DON/RN Supervisor will review the Care Plans to insure that it is reflective of the resident's current status each week for the next 4 weeks.</p> <p>The results of these reviews will be reviewed in the CQI Committee meeting for further monitoring and continued compliance.</p>	

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F 280	<p>Continued From page 4</p> <p>reflect the resident's side rails had been discontinued.</p> <p>2. Observations on 07/16/12, of Resident #2 revealed the resident had one-half side rails in place when the resident was in bed at 1:27 PM, 2:38 PM, and 3:52 PM.</p> <p>A review of Resident #2's admission physician's orders dated 02/24/12, revealed an order for one-half side rail use.</p> <p>A review of Resident #2's care plan revealed no evidence the side rail use had been addressed.</p> <p>Interview on 07/16/12, at 2:55 PM, with the MDS Coordinator revealed Resident #1's side rails still being care planned was an oversight and the resident's side rails had been removed on 06/28/12, after a bruise was found on the resident's forehead. The interview further revealed Resident #2's side rail use was not addressed on the care plan because there was not an order for the side rails in the computer. The MDS Coordinator also stated that he/she had assessed and talked to the resident but did not realize he/she had side rails in use.</p> <p>Interview on 07/16/12, at 3:05 PM, with the Director of Nursing (DON) revealed the care plan for Resident #1 should have been revised when side rail use was discontinued. The DON further stated Resident #2's side rails had been in place since admission even though it was not addressed on the care plan. The interview further revealed the DON felt like the care plans had not been revised because both instances were overlooked.</p>	F 280		

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