

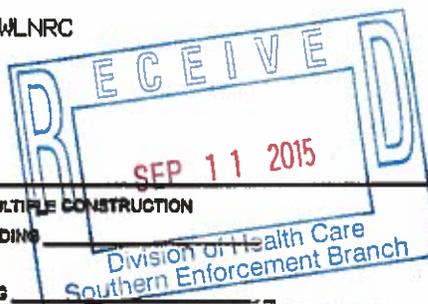
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/20/2015
NAME OF PROVIDER OR SUPPLIER WEST LIBERTY NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 774 LIBERTY ROAD WEST LIBERTY, KY 41472	

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F 000	INITIAL COMMENTS A standard health survey was conducted on 08/18-20/15. Deficient practice was identified with the highest scope and severity at "E" level.	F 000	To the best of my knowledge and belief, as 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 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.	
F 226 SS=D	483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, review of employee personnel files, and review of the facility policy, it was determined the facility failed to implement written policies that prohibit mistreatment, neglect, and abuse of residents, as evidenced by five (5) of five (5) reviewed employee files failing to contain a pre-employment screening for the Nurse Aide Abuse Registry and the Adult Misconduct Registry (Employees #1, #2, #3, #4, and #5). The findings include: Review of the facility policy and procedure titled "Resident Advocacy Protocols," not dated, revealed pre-employment screening would be completed on all employees including Abuse	F 226	The facility contracts with an employment screening company, Orange Tree, which completes all pre-hire screening requirements, including the Nurse Aide Abuse Registry Check and KY Adult Misconduct Registry check. Orange Tree has provided a clarification letter to the facility which verifies that Employee #1, 2, 3 and 4 had the required abuse registry checks performed during the routine background checks prior to being hired by the facility. None of these employees were found to be listed on the Nurse Aide Abuse Registry nor the KY Adult Misconduct Registry. Employee #5 was not a new hire. This employee transferred from another facility with an original hire date of August 2012. The Nurse Aide Abuse Registry Check for employee #5 was completed upon initial hire and this employee was NOT found to be listed on the Nurse Aide Abuse Registry Check. The most recent Nurse Aide Abuse Registry check for Employee #5 was completed	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

9-11-15

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

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F 228	<p>Continued From page 1</p> <p>Registry Report. Further review of the policy revealed the facility would not hire or retain any employee with a history of abuse or neglect if that information was known to the facility.</p> <p>Review of Employee #1's personnel record revealed the employee was hired on 05/20/15; however, there was no documented evidence a Nurse Aide Abuse Registry check or Adult Misconduct Registry check was completed prior to the date of hire.</p> <p>Review of Employee #2's personnel record revealed the employee was hired on 05/27/15; however, there was no documented evidence a Nurse Aide Abuse Registry check or Adult Misconduct Registry check was completed prior to the date of hire.</p> <p>Review of Employee #3's personnel record revealed the employee was hired on 04/28/15; however, there was no documented evidence a Nurse Aide Abuse Registry check or Adult Misconduct Registry check was completed prior to the date of hire.</p> <p>Review of Employee #4's personnel record revealed the employee was hired on 04/28/15; however, there was no documented evidence a Nurse Aide Abuse Registry check or Adult Misconduct Registry check was completed prior to the date of hire.</p> <p>Review of Employee #5's personnel record revealed the employee was hired on 08/27/12; however, there was no documented evidence a Nurse Aide Abuse Registry check or Adult Misconduct Registry check was completed prior to the date of hire.</p>	F 228	<p>on 2/26/2013. This individual was NOT found to be listed on the Nurse Aide Abuse Registry. To ensure compliance, the Adult Misconduct Registry was checked for Employee #5 by Orange Tree on 9/9/15. Employee #5 was found NOT to be listed on the KY Adult Misconduct Registry. Orange Tree was contacted by the Administrator on 9/8/15. Orange Tree provided a clarification letter on 9/9/15 indicating that any employee hired since August 1, 2014, has been cross referenced with the Nurse Aide Abuse Registry and the KY Adult Misconduct Registry. No employees hired were found to be on either list. From here forward, Orange Tree will individually list in the employee information that both the Nurse Aide Abuse Registry and the KY Adult Misconduct Registry have been checked. The results will be listed individually based on the information contained on the websites associated with each registry.</p> <p>The Acting Administrator will review employee files of all new hires for thirty days to ensure that all required information is contained in the personnel hire packet, including the Nurse Aide Abuse Registry Check and the KY Adult Misconduct Registry check.</p>		

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F 226	Continued From page 2 Interview with the Business Office Manager (BOM) on 08/20/15 at 5:00 PM revealed she was hired as the BOM on 07/22/15. The BOM stated she was aware of the required Nurse Aide Abuse Registry checks and had been doing those since she was hired. The BOM stated the DON was in charge of completing the checks before the BOM was hired in July 2015. The BOM further stated she was not aware of the requirement for the Adult Misconduct Registry Check and had not been checking the Adult Misconduct Registry. Interview with the Director of Nursing (DON) on 08/20/15 at 5:15 PM revealed she was responsible for completing the Nurse Aide Abuse Registry checks for all new hires prior to 07/22/15 when the BOM was hired. She stated she thought she had done them, but stated she did not know for sure. She stated the checks should be in the personnel record. Additional interview revealed the DON stated she was not aware of the requirement for the Adult Misconduct Registry check and had not been checking this registry. Interview with the Acting Administrator on 08/20/15 at 6:45 PM, revealed the facility used a contracted agency for the Abuse and Criminal Background checks and stated she thought the program included the Nurse Aide Abuse Registry. The Acting Administrator further stated she was not aware of the requirement for the Adult Misconduct Registry checks.	F 226	Thereafter, at least two hires per month will be reviewed by the Acting Administrator to ensure that checks are completed appropriately. The results of these reviews will be forwarded to the monthly QAPI Meeting for further monitoring and continued compliance.	9/11/15	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES: The resident has the right to choose activities, schedules, and health care consistent with his or	F 242	The Dietary Manager spoke with resident #3 and #7 in regard to likes and dislikes on 9/4/15 regarding food preferences and beverages. Food and Beverage preference		

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F 242	<p>Continued From page 3</p> <p>her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined the facility failed to honor resident choices regarding food and drink likes and dislikes for two (2) of twelve (12) sampled residents (Resident #3 and Resident #7). Observations during the meal service revealed Resident #3 received items on the resident's meal tray that were listed as foods that the resident disliked. Observations during medication pass revealed the resident received medication that was placed in a food item that the resident did not like. Resident #7 was observed to receive an item on the resident's disliked food list on the dinner tray.</p> <p>The findings include:</p> <p>Review of the facility policy, "Alternate Foods," dated 08/01/12, revealed, "substitutions are provided for any food dislikes or allergy of the resident." The policy also stated, "menu substitutions may arise out of individual dislikes, these are handled through the tray cards and noted in the resident's cardex file."</p> <p>1. Review of the medical record for Resident #7 revealed he facility admitted the resident on 08/20/10 with diagnoses of Mental Disorder, Anxiety State, Alzheimer's, Psychosis, Depressive Psychosis, and History of Breast</p>	F 242	<p>was updated for resident #3 and #7 by Dietary Manager on 9/4/15.</p> <p>The Dietary Manager reviewed food and Beverage preference list with each resident residing in facility. The food choice and beverage preference list for each resident was updated by Dietary Manager by 9/11/15. The Dietary Manager educated all staff on 8/26/15 regarding the importance of the residents self determination and participation in all aspects of life specifically related to food preferences. Staff were reminded to check tray cards closely and to adhere to resident food and beverage preference list.</p> <p>The acting administrator will monitor at least three trays per week across all shifts for three months to ensure food choice and beverages are honored. The results of these reviews will be forwarded to the monthly QAPI meeting for further monitoring and continued compliance.</p>	9/11/15	

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F 242	<p>Continued From page 4</p> <p>Malignancy with Mastectomy. Review of the resident's Quarterly Minimum Data Set (MDS) dated 07/30/15 revealed the resident to have a Brief Interview Review of Mental Status (BIMS) score of 99 which indicates the resident was noninterviewable and severely cognitively impaired. Review of Resident #7's meal card revealed that a dislike for ice in cold beverages was documented on the meal card. Further review of the resident's Care Plan, dated 10/15/14 revealed, "the resident does not like ice in cold beverages per family request." Review of Resident #7's disliked food list revealed the resident disliked ice in cold beverages.</p> <p>Observation on 08/19/15 at approximately 5:45 PM revealed Resident #7 received ice water on the dinner tray. Continued observation revealed Resident #7 drank the lemonade (without ice) and coffee that were served on the dinner tray, but did not drink the ice water. Resident #7 stated during observation that he/she did not like ice in any drinks.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #2 on 08/20/15 at 4:28 PM revealed she gave Resident #7 the dinner tray, and the resident did not say anything to her about not liking ice in his/her cold drinks. She stated she could not remember if Resident #7's meal card noted the resident's dislike for ice in his/her cold drinks. She also stated that they find out what the resident's likes and dislikes are by the meal card. Further interview revealed it was important that residents received foods they liked because they could become dehydrated and lose weight.</p> <p>Interview with the Dietary Aide on 08/20/15 at</p>	F 242			

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F 242	<p>Continued From page 5</p> <p>3:50 PM revealed Resident #7 had a list of likes and dislikes on his/her meal card; however, she did not remember putting ice in the resident's water on the dinner tray. She stated that one of the SRNAs could have put the ice in the water when delivering the tray to Resident #7.</p> <p>2. Review of the medical record for Resident #3 revealed the facility admitted the resident on 04/14/14 with diagnoses that included Congestive Heart Failure, Gout, Anxiety, and Chronic Respiratory Failure. Review of the Quarterly MDS dated 08/22/15 revealed Resident #3 was assessed by the facility to have a BIMS score of 9, indicating the resident had moderate cognitive impairment. Review of the Comprehensive Care Plan dated 01/22/15 revealed an intervention to maintain a current list of food likes and dislikes for Resident #3. The Comprehensive Care Plan did not include a list of the resident's likes and dislikes. Review of Resident #3's meal card revealed the resident disliked carrots and chocolate.</p> <p>Observation on 08/18/15 at 5:04 PM revealed Resident #3 was served chicken and dumplings with carrots and chocolate pudding for the evening meal. Continued observation revealed Resident #3 stated, "I can't eat this."</p> <p>Observation during a medication pass on 08/19/15 at 11:31 AM, revealed Carafate (medication used to coat the stomach) 1 gram (g) was prepared for Resident #3 in chocolate pudding. Licensed Practical Nurse (LPN) #1 entered the room of Resident #3 and stated, "I have your medicine." Further observation revealed Resident #3 refused the medication because it was prepared in chocolate pudding.</p>	F 242	<p>On 9/4/15 the Dietary Manger spoke with resident #3 in regard to preferred food choice for preparation for medication passes. The Director of Nursing updated all resident EMAR medications with preferred food choice.</p>		

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F 242	<p>Continued From page 6</p> <p>The LPN disposed of the medication and re-prepared the medication in yogurt and the medication was administered to Resident #3.</p> <p>Interview with Resident #3 on 08/18/15 at 6:07 PM, revealed he/she did not like carrots or chocolate and wished not to be served either item.</p> <p>Interview with LPN #1 on 08/19/15 at 12:30 PM, revealed she was not aware Resident #3 disliked chocolate.</p> <p>Interview with the Dietary Manager on 08/20/15 at 3:45 PM revealed the dietary staff was aware of all residents' likes and dislikes because they each have a tray card with the information on it. She stated the cook that serves was the one responsible for making sure the residents' likes and dislikes were honored. She further stated the resident should not have received something they did not like on their meal tray, it was just overlooked. She stated, "A lot of times the aide will catch it on the floor and replace it."</p> <p>Interview with the Dietitian on 08/20/15 at 3:55 PM revealed that it was very important for the staff to honor food preferences. She stated this was their home and they should get the foods and drinks they like. She also stated it was important for the residents' food preferences to be honored because if not their intake can go down which might cause the resident to have a decline in health. The Dietitian also stated that she expected staff to honor the residents' choices and food likes and dislikes.</p> <p>Interview with the DON (Director of Nursing) on 08/20/15 at 5:35 PM revealed that Dietary</p>	F 242	<p>On 9/10/15 DNS educated all nursing staff with any updates of food preference with medication passes.</p> <p>The DON and RN supervisor will monitor at least 10 medication opportunities per week on different shifts for three months, and then monthly thereafter, to ensure that medication administration with preferred food choice is passed appropriately. Any issues identified will be addressed via one on one education with the nurse being observed. The results of the medication pass audits will be forwarded to the monthly QAPI meeting for further monitoring and continued compliance.</p>		

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F 242	Continued From page 7 provides cards with each resident's likes and dislikes on them. The DON stated this information should also be on the Comprehensive Care Plan and the nurses should be aware of the residents' likes and dislikes. She stated dietary staff and the nurse aides check the residents' tray cards when delivering the trays. "I expect each resident to have their likes and dislikes honored when they are served their meals." The DON stated that residents always have a choice of what they eat or drink, and those choices should be honored.	F 242			
F 282 SS=D	483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to provide care in accordance with the Comprehensive Plan of Care for one (1) of twelve (12) sampled residents (Resident #10).	F 282	On 8/20/15 the RN Supervisor placed leg strap on resident #10 to secure the tubing to prevent pulling, which is reflected in the plan of care. On 8/20/15 the RN supervisor also assessed resident #10 for sheepskin on footboard. The RN supervisor placed the sheepskin on footboard which is reflected in the plan of care. RN supervisor found no negative outcomes related to lack of leg strap and/or lack of sheepskin not placed on footboard.		

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F 282	<p>Continued From page 8</p> <p>Resident #10's Comprehensive Care Plan contained interventions for an indwelling urinary catheter that included "to secure the tubing to prevent pulling." Observations on 08/20/15 revealed the catheter was attached to a bedside drainage bag; however, the tubing was not secured to the resident's leg in accordance with the plan of care. Furthermore, Resident # 10 had a care plan intervention for "sheepskin to footboard," but observations on 08/20/15 revealed there was no sheepskin applied to the resident's footboard.</p> <p>The findings include:</p> <p>Interview with the Director of Clinical Operations on 08/20/15 at 4:50 PM revealed the facility did not have a policy related to following the resident's plan of care. She stated the facility follows the Resident Assessment Instrument (RAI) Manual and the Federal Regulations Manual for their care plans.</p> <p>Review of Resident #10's medical record revealed the facility admitted Resident #10 on 08/05/15 with diagnoses of Urinary Retention, History of Tibia Plateau Fracture with repair, Dementia, and Renal Stones. Review of the admission Minimum Data Set (MDS) assessment dated 08/12/15 revealed Resident #10 required the use of an indwelling urinary catheter. Review of the care plan dated 08/05/15 revealed catheter care was to be done daily and the catheter and tubing were to be secured to prevent pulling. Further review of the care plan dated 08/05/15 revealed that sheepskin was to be added to the footboard of the resident's bed to prevent further skin breakdown to his/her feet if the resident's feet were to touch the footboard.</p>	F 282	<p>The MDS coordinator and interdisciplinary team will continue walking care plans with all residents to ensure all care plan interventions/orders are implemented/ followed.</p> <p>The team will audit all care plans to ensure that provided care is in accordance with the residents Comprehensive plan of care by 9/10/15.</p> <p>On 9/10/15; The acting Administrator educated the interdisciplinary team in regard to walking care plans to ensure that all residents care plans are implemented as written.</p> <p>DON or RN supervisor will audit/review three care plans per week for four weeks to ensure that all interventions are implemented as written. Thereafter, DON or RN will audit/review two care plans per month for three months. The results of these audits/reviews will be forwarded to monthly QAPI meetings for further monitoring and continued compliance.</p>	9/11/15	

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F 282	<p>Continued From page 9</p> <p>Observation of Resident #10 on 08/20/15 at 12:50 PM during urinary catheter care revealed Resident #10's catheter was attached to a bedside drainage bag; however, the tubing was not secured to the resident's leg to prevent pulling. Further observations on 08/20/15 at 10:25 AM, 11:25 AM, and 12:45 PM revealed that sheepskin was not on the footboard of the resident's bed.</p> <p>Interview with the Charge Nurse, Licensed Practical Nurse (LPN) #1, on 08/20/15 at 2:15 PM revealed she had signed off on the order for the resident to have sheepskin on his/her footboard, but stated she got "sidetracked" and "forgot" to put it on the resident's bed. She further revealed that she did not normally work on that side of the hallway and she was not familiar with the resident. She also stated she did not realize that the sheepskin was an intervention on the care plan.</p> <p>Interview with the MDS Specialist on 08/20/15 at 4:55 PM revealed she was responsible for developing the care plans and updating the care plans as needed. However, the charge nurses were responsible to ensure staff was following the care plans.</p> <p>Interview with the Director of Nursing (DON) on 08/20/15 at 5:35 PM revealed the charge nurses were responsible to ensure staff was following the care plans. She further stated no problems had been identified concerning staff not following the care plans. She stated that staff was trained on following the care plans. She also stated the care plans were available for the staff and they are responsible to look at and follow them. She</p>	F 282			

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NAME OF PROVIDER OR SUPPLIER: WEST LIBERTY NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 774 LIBERTY ROAD WEST LIBERTY, KY 41472		
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F 282	Continued From page 10 stated that staff was to report during shift report any changes to the care plan. She stated she expected staff to follow the resident's care plan at all times.	F 282			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined that the facility failed to ensure residents who had an indwelling catheter received appropriate treatment and services to prevent trauma or injury for one (1) of twelve (12) sampled residents (Resident #10). Resident #10 required the use of an indwelling urinary catheter and the facility developed care plan interventions to secure the catheter tubing to prevent trauma or injury. However, observations revealed the catheter tubing was not secured for Resident #10 to prevent trauma. The findings include: Review of the facility's policy and procedure.	F 315	On 8/20/15 the RN supervisor placed leg strap on resident # 10. The RN assessed resident #10 and found no negative outcomes related to lack of leg strap. On 8/20/15 the RN supervisor assessed all residents utilizing a foley catheter to ensure leg straps were in place. Any resident noted without a leg strap had one applied by RN supervisor on 8/20/15. The Director of Nursing educated all nursing staff regarding the importance of caring for residents with a foley catheter. Emphasis was placed on proper cleaning techniques and utilization of leg straps to secure catheter tubing to prevent trauma or injury. The Director of Nursing or RN supervisor will check all residents with a indwelling catheter at least three times per week for four weeks to ensure that catheter care is appropriate and leg strap is in place. Thereafter, each resident will be assessed weekly for three months. The results will be forwarded to monthly QAPI meeting for further monitoring and continued compliance.	9/11/15	

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F 315	<p>Continued From page 11</p> <p>"Catheters/Urinary/Catheter Care," dated 02/01/12, revealed that staff was to minimize trauma to the urethra and that a leg band and catheter tubing holder were to be used with urinary catheters.</p> <p>Review of the medical record revealed the facility admitted Resident #10 on 08/05/15, with diagnoses that included Urinary Retention, History of Tibia Plateau Fracture with repair, and Renal Stones. Review of the Physician's Orders for Resident #10 revealed an order dated 08/08/15 for Resident #10 to have an indwelling urinary catheter due to diagnoses of Urinary Retention, History of Tibia Plateau Fracture with repair, and Renal Stones.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated 08/12/15 revealed the facility assessed Resident #10 to have a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe impairment in cognition. The MDS also revealed the resident required the extensive assistance of two staff persons for toileting and required an indwelling urinary catheter.</p> <p>Review of the Care Plan dated 08/05/15, revealed the facility addressed the use of the indwelling catheter for Resident #10 with interventions which included securing catheter tubing to prevent pulling.</p> <p>Observation of Resident #10 on 08/20/15 at 10:25 AM revealed the resident lying in bed on a pressure-relieving mattress with a urinary catheter drainage bag hanging from the bed's lower railing. Further observation on 08/20/15, at 12:50 PM revealed facility staff performed</p>	F 315			

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F 315	<p>Continued From page 12</p> <p>catheter care for Resident #10. After completion of the catheter care, the catheter tubing was not secured to prevent potential tension/trauma for Resident #10.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #1 on 08/20/15 at 1:50 PM revealed that she had not realized Resident #10's urinary catheter was not anchored. She stated she did not know who was responsible for making sure indwelling urinary catheters were anchored properly. Furthermore, she stated that the catheter should have been anchored and that staff was trained to anchor urinary catheters to prevent trauma.</p> <p>Interview with Licenses Practical Nurse (LPN) #1 on 08/20/15 at 2:15 PM revealed when the nurses do their rounds they check to make sure that catheters were secured with a leg band. She stated she usually checks once per shift to make sure they were secured. She stated that the nurse was responsible for putting the leg band on the resident to secure the catheter tubing to prevent injury. She said the SRNAs tell the nurses if the resident's leg band has been soiled so it can be changed. Furthermore, she stated that she did not know that Resident #10's catheter was not anchored. She stated that any resident that had a catheter was supposed to have a leg band to anchor it.</p> <p>Interview with the Director of Nursing on 08/20/15 at 5:35 PM revealed that staff was to use leg bands to secure catheters to residents. She stated the supervisors and nurses monitor staff to make sure residents were getting the care they need, and that all staff was trained on anchoring catheters to residents with leg bands. She also</p>	F 315			

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F 315	Continued From page 13 stated she had not found any problems with residents not having their urinary catheters anchored to their leg.	F 315			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure it was free of a medication error rate of five (5) percent or greater. Medication pass observations on 08/19/15 resulted in the assessment of two (2) medication errors out of twenty-five (25) opportunities, reflecting a medication error rate of eight (8) percent. Licensed Practical Nurse (LPN) #1 administered a dose of medication before meals and the physician's order stated after meals. Additionally, Registered Nurse (RN) #1 failed to flush a gastrostomy tube (g-tube) prior to administration of medication. The findings include: Interview with the Acting Administrator on 08/20/15 at 1:40 PM, revealed the facility did not have a policy or procedure on Medication Administration. Review of the facility's policy and procedure titled "Enteral Nutrition," not dated, revealed staff was to flush the g-tube with at least 30 milliliters (ml)	F 332	On 8/21/2015, the Medical Record Clerk changed the time code on the Simethicone for Resident #3 to 9am, 1pm, 6pm, and 9pm to ensure that the medication would be administered after meals as ordered. RN #1 flushed the feeding tube for Resident #13 immediately after the meds were administered and the tube was patent at that time. This resident does not receive Dilantin. By 9/10/15, the DNS and RN Supervisor reviewed the orders for all residents to ensure that any medication specifically prescribed to be given after meals had the appropriate time code in place to ensure that meds were administered as directed by the physician. The facility has two additional residents who receive medications via g-tube. The DNS visually observed these residents on the evening shift 8/20/2015 to ensure that the tube feeding was infusing without difficulty		

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F 332	<p>Continued From page 14</p> <p>of warm water prior to administering medication through the g-tube. Further review revealed the water should drain by gravity and flow easily.</p> <p>1. Observation of a medication administration pass with LPN #1 on 08/19/15 at 11:33 AM revealed Simethicone (medication used to relieve gas) was prepared and administered to Resident #3 before the noon meal.</p> <p>Review of Resident #3's physician's orders, dated August 2015, revealed an order for Simethicone Gas Relief 125 milligrams (mg), two tablets, 250 mg, to be administered by mouth after meals and at bedtime.</p> <p>2. Observation of a medication administration pass with RN #1 revealed Baclofen (a muscle relaxer) 10 mg and Calcium (a supplement) 500 mg was prepared for Resident A. Further review revealed RN #1 was not observed to flush the g-tube with water prior to administration of the medication.</p> <p>Review of Resident A's physician's orders dated August 2015, revealed an order for Baclofen 10 mg per tube three times a day. Additional review revealed an order for Calcium 500 mg per tube three times a day.</p> <p>Interview with LPN #1 on 08/20/15 at 1:42 PM, revealed she thought the order for Resident #3's Baclofen said "with meals." Additional interview revealed the LPN stated she knew the medication was to relieve gas and therefore should be taken after meals.</p> <p>Interview with RN #1 on 08/20/15 at 5:00 PM revealed the RN stated she knew she had made</p>	F 332	<p>The DNS provided additional education to all licensed staff by 9/10/15 regarding the appropriate guidelines for administering medications. Special emphasis was placed on the importance of choosing time codes that adhere to the specific medication orders and the importance of flushing feeding tubes prior to administering medications. The pharmacist will conduct monthly med pass audits for the next six months. The DNS or RN Supervisor will monitor at least 10 medication opportunities per week on different shifts for three months, and then monthly thereafter, to ensure that medication administration is completed appropriately. The observations will include at least one resident who receives medication via feeding tube. Any issues identified will be addressed via one on one education with the nurse being observed. The results of the medication pass audits will be forwarded to the monthly QAPI meeting for further monitoring and continued compliance.</p>	9/11/15	

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F 332	Continued From page 15 a mistake and stated, "I was just nervous." RN #1 stated it was important to flush the g-tube prior to medication administration to ensure patency.	F 332			
F 366 SS=E	Interview with the Director of Nursing (DON) on 08/20/15 at 6:00 PM, revealed she routinely monitored all staff that administers medications. The DON further stated she completed the monitoring at least annually for all staff. The DON stated it was her expectation for the staff to administer medications as ordered by the physician. Additionally, the DON stated she expected staff to always flush the g-tube before administering medication and per the policy and procedure. 483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to provide food substitutes of similar nutritive value. The menu specified chicken and dumplings, carrots, and cornbread for the hot foods to be served at the evening meal on 08/18/15. The alternate/substitute food item for the chicken and dumplings was bologna sandwiches and chicken noodle soup. The findings include: Review of the menu spreadsheet for the evening	F 366	Acting Administrator, Director of Nursing and Dietary Manager spoke with resident #3 on 9/4/15 regarding food preferences/variety/resident choice as related to meal service. Specific likes/dislikes were noted and implemented. Review of resident counsel minutes for prior three months by Activities Director on 9/4/15 revealed no resident complaints regarding alternate food. No other resident voiced complaints of alternate food choices. The days of 18th-20th. The Dietary Manager will receive education no later than 9/4/15 by the Regional Dietary Manager regarding the importance of substitutes offered of similar nutritive value to residents who refuses food served.		

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F 366	<p>Continued From page 16</p> <p>meal on 08/18/15 revealed the menu specified chicken and dumplings, carrots, and cornbread were to be served as the hot food items.</p> <p>Observation of the tray line on 08/18/15 at the evening meal revealed the steam table contained chicken and dumplings, carrots, and cornbread. Further observation revealed staff was serving bologna sandwiches and chicken noodle soup as the alternate/substitute food for the chicken and dumplings.</p> <p>Interview with the Dietary Manager (DM) at 5:10 PM on 08/20/15 revealed bologna sandwiches and chicken noodle soup were the only alternate/substitute food items staff had prepared for the evening meal on 08/18/15. The DM stated staff prepared the bologna sandwiches and chicken noodle soup as the alternate/substitute for the chicken and dumplings because residents liked the bologna sandwiches and chicken noodle soup. The DM further stated she thought the bologna sandwiches and chicken noodle soup were the same nutritive value as the chicken and dumplings, carrots, and cornbread.</p> <p>Interview with the Registered Dietitian (RD) at 5:20 PM on 08/20/15 revealed the RD agreed the bologna sandwiches and chicken noodle soup were not similar in nutritive value to the chicken and dumplings, carrots, and cornbread.</p>	F 366	<p>Based on this information the Dietary Manager changed current menu's on 9/4/15 to reflect requirements related to offering substitutes of similar nutritive value.</p> <p>The Acting Administrator will monitor at least three meals per week across all shifts for four weeks to ensure that substitutes offered are of similar nutritive value. Thereafter, the Acting Administrator will monitor two meals per month for three months. The results of these reviews will be forwarded to monthly QAPI meetings for further monitoring and continued compliance.</p>	9/11/15	
F 493 SS=D	<p>483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN</p> <p>The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the</p>	F 493	<p>The Region Vice President (RVP) appoints the administrator of each center under his/her purview who is licensed by the State where licensing is required; and responsible for the management of the facility.</p>		

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F 493	<p>Continued From page 17</p> <p>management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to appoint an administrator that was licensed by the state. Interview and record review revealed the Acting Administrator had a temporary permit that expired on 03/23/15. Interview with the supervisor of the Acting Administrator revealed she was aware that the Acting Administrator's temporary permit had expired, but failed to appoint a licensed administrator to manage the facility.</p> <p>The findings include:</p> <p>Review of the facility's Position Description titled "Administrator," not dated, revealed the Administrator was required to have a Nursing Home Administrator License.</p> <p>Review of a letter from the Board of Licensure for Long-Term Care Administrators, dated 08/11/15, revealed the Administrator's temporary permit was valid for only six (6) months and was terminated effective 03/23/15. Further review of the letter revealed if the Administrator was continuing to practice under the temporary permit, she "must immediately cease and desist practicing in" the state.</p>	F 493	<p>The RVP was serving as mentor to the Acting Administrator and in the role of Administrator at this center once the temporary permit expired for the then Acting Administrator. Notification was sent to the OIG on 8/28/2015 by the licensed administrator, W. Meade with her current proof of license in Kentucky. At no point was the facility without a licensed administrator and no residents were affected by this practice.</p> <p>The system for notifying the state agency of a change in long term care administrator assignments has been reviewed and revised and future notification will be initiated from the Human Resources department at our corporate support center upon hire or change in position/status.</p> <p>The Director of Human Resources will audit this notification on a monthly basis for six months and report results at the monthly QAPI meeting.</p>	9/11/15	

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F 493	<p>Continued From page 18</p> <p>Observations on 08/18/15 at 3:55 PM and 5:23 PM revealed the Acting Administrator was wearing a name badge titled "Administrator."</p> <p>Interview with the Acting Administrator on 08/20/15 at 7:05 PM, revealed she came to the facility on 06/03/14 as the Administrator Designee and became the Administrator when she received the temporary permit on 09/23/14. The Acting Administrator stated she was required to take the Nursing Home Administrator Test to become a licensed administrator and stated she failed the test. The Acting Administrator stated she was aware the temporary permit expired on 03/23/15 but stated she did not inform the Office of Inspector General and continued in the role of Administrator.</p> <p>Interview with the Regional Vice President on 08/19/15 at 9:25 AM, and 08/20/15 at 7:30 PM, revealed she was the direct supervisor of the Acting Administrator and was not aware of the letter from the Board of Licensure for Long-Term Care Administrators informing the Acting Administrator to cease and desist practicing as the Administrator. The Regional Vice President stated she was aware the Acting Administrator had failed her Nursing Home Administrator Test and was practicing under the Regional Vice President's license. The Regional Vice President stated she did not notify the Office of Inspector General of the temporary permit expiration and made no changes in the assignment of the facility Administrator.</p>	F 493			

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185274	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 9/11/2015
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Name of Facility WEST LIBERTY NURSING & REHABILITATION CENTER	Street Address, City, State, Zip Code 774 LIBERTY ROAD WEST LIBERTY, KY 41472
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This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0226</u> Reg. # <u>483.13(c)</u> LSC _____	Correction Completed 09/11/2015	ID Prefix <u>F0242</u> Reg. # <u>483.15(b)</u> LSC _____	Correction Completed 09/11/2015	ID Prefix <u>F0282</u> Reg. # <u>483.20(k)(3)(ii)</u> LSC _____	Correction Completed 09/11/2015
ID Prefix <u>F0315</u> Reg. # <u>483.25(d)</u> LSC _____	Correction Completed 09/11/2015	ID Prefix <u>F0332</u> Reg. # <u>483.25(m)(1)</u> LSC _____	Correction Completed 09/11/2015	ID Prefix <u>F0366</u> Reg. # <u>483.35(d)(4)</u> LSC _____	Correction Completed 09/11/2015
ID Prefix <u>F0493</u> Reg. # <u>483.75(d)(1)-(2)</u> LSC _____	Correction Completed 09/11/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <input checked="" type="checkbox"/>	Reviewed By <u>JB</u>	Date: <u>10/20/15</u>	Signature of Surveyor: <u>Donetta Ball</u>	Date: <u>10/20/15</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 8/20/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 100340	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 9/11/2015
Name of Facility WEST LIBERTY NURSING & REHABILITATION CENTER	Street Address, City, State, Zip Code 774 LIBERTY ROAD WEST LIBERTY, KY 41472	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>N0105</u> Reg. # <u>902 KAR 20:300-5(3)</u> LSC _____	Correction Completed 09/11/2015	ID Prefix <u>N0116</u> Reg. # <u>902 KAR 20:300-6(2)(c)</u> LSC _____	Correction Completed 09/11/2015	ID Prefix <u>N0194</u> Reg. # <u>902 KAR 20:300-7(4)(c)2.</u> LSC _____	Correction Completed 09/11/2015
ID Prefix <u>N0214</u> Reg. # <u>902 KAR 20:300-8(4)(c)</u> LSC _____	Correction Completed 09/11/2015	ID Prefix <u>N0237</u> Reg. # <u>902 KAR 20:300-8(12)(c)1.</u> LSC _____	Correction Completed 09/11/2015	ID Prefix <u>N0275</u> Reg. # <u>902 KAR 20:300-10(4)(d)</u> LSC _____	Correction Completed 09/11/2015
ID Prefix <u>N0319</u> Reg. # <u>902 KAR 20:300-15(2)(b)1.</u> LSC _____	Correction Completed 09/11/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>ad</u>	Reviewed By <u>ad</u>	Date: <u>10/20/15</u>	Signature of Surveyor: <u>Alisia Dunn</u>	Date: <u>10/20/15</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 8/20/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		

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

PRINTED: 09/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2015
NAME OF PROVIDER OR SUPPLIER WEST LIBERTY NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 774 LIBERTY ROAD WEST LIBERTY, KY 41472	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01 One story, Type III (211), 1961, protected ordinary construction with a two-story, Type III (211), protected ordinary addition</p> <p>Plan Approval: 1961, 1993</p> <p>Survey under: NFPA 101 (2000 Edition), Chapter 19 (existing health care)</p> <p>Facility type: SNF/NF</p> <p>Smoke Compartments: 4</p> <p>Fire Alarm: Complete fire alarm with smoke detectors</p> <p>Sprinkler System: Complete automatic sprinkler system</p> <p>Generator: Type II, Diesel installed 1993</p> <p>A standard Life Safety Code survey using 2786S (Short Form) was conducted on 08/20/15. West Liberty Nursing and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was 47 residents with the facility being licensed for 48 beds.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 42.3.70(a) et seq. (Life Safety from Fire) with the highest scope and severity at "F" level.</p>	K 000	To the best of my knowledge and belief, as 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 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Amy Johnson

TITLE

Acting Administrator

DATE

9-11-15

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 those documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

09/11/2015 16:44 6067432540

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2015
NAME OF PROVIDER OR SUPPLIER WEST LIBERTY NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 774 LIBERTY ROAD WEST LIBERTY, KY 41472		
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K 052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to ensure the fire alarm system was maintained according to National Fire Protection Association (NFPA) Standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, 48 residents, staff, and visitors.</p> <p>The findings include:</p> <p>Record review of the quarterly fire alarm inspection records on 08/20/15 at 2:48 PM, with the Regional Maintenance Director, revealed inspection reports dated 03/11/15 and 06/18/15 identified the fire alarm batteries had failed the load test. Further record review revealed the batteries were not replaced until 08/08/15. Interview with the Maintenance Director revealed</p>	K 052	<p>West Liberty Nursing & Rehabilitation Center strives to observe all life safety standards. West Liberty Nursing & Rehabilitation contracted with the company Simplex account from September 2014 to July 2015. West Liberty replaced the contract with Sentry Fire in August 2015.</p> <p>During inspection reports dated 3/11/15 and 6/18/15 identified the fire alarm batteries had failed the load test however did not do a follow up to replace the batteries. This company would not complete their duties in a timely manner.</p> <p>West Liberty contracted with Sentry Fire in August and the batteries were replaced on 8/6/15.</p> <p>The Maintenance Director received additional education by the Acting Administrator on 8/25/15 the importance of ensuring the fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72.</p> <p>Maintenance Director will monitor monthly for three months and quarterly thereafter.</p> <p>Results will be forwarded to the Safety Committee monthly to determine further continued compliance.</p>	9/11/15	

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K 052	<p>Continued From page 2</p> <p>the facility had problems with the company contracted to replace the batteries showing up, and this was the reason for the delay.</p> <p>The findings were revealed to the administrator during the exit conference.</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>7-1.1 Scope. Chapter 7 shall cover the minimum requirements for the inspection, testing, and maintenance of the fire alarm systems described in Chapter 1, 3, and 5 and for their initiation and notification components described in Chapter 2 and 4. The testing and maintenance requirements for one and two-family dwelling units shall be located in Chapter 8.</p> <p>Single station detectors used for other than one- and two-family dwelling units shall be tested and maintained in accordance with Chapter 7. More stringent inspection, testing, or maintenance procedures that are required by other parties shall be permitted.</p> <p>7-2.2* Fire alarm systems and other systems and equipment that are associated with fire alarm systems and accessory equipment shall be tested according to Table 7-2.2.</p> <p>NFPA 101 (2000 Edition).</p> <p>4.5.7 Maintenance. Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be</p>	K 052			

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K 052	Continued From page 3 maintained unless the Code exempts such maintenance.	K 052		
K 056 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure all areas were fully sprinkler protected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, sixteen (16) residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 08/20/15 at 1:15 PM, revealed an automatic sprinkler head was located less than one foot from a light fixture, which extended below the automatic sprinkler head deflector. Interview with the Regional Maintenance Director revealed the automatic sprinkler head had been</p>	K 056	<p>West Liberty Nursing and Rehabilitation Center strive to observe all life safety standards.</p> <p>On 8/25/15, the Maintenance Director moved the light fixture 12 inches from the sprinkler head to ensure that the area was fully sprinkler protected according to National Fire Protection Association (NFPA)</p> <p>The acting administrator and Maintenance Director toured the building to ensure all sprinklers have complete coverage for all portions of the building. No negative outcomes from all other sprinkler heads were noted.</p> <p>On 8/25/15; The acting administrator provided education to Maintenance Director on the importance of compliance rounds. Any issues found will be discussed with the Acting Administrator.</p> <p>Results will be forwarded to the Safety Committee monthly to determine further continued compliance.</p>	9/11/15

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2015																																	
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K 056	<p>Continued From page 4 overlooked by the facility.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception:* Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met:</p> <p>(a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings.</p> <p>(b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill.</p> <p>(c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.</p> <p>Table 19.1.6.2 Construction Type Limitations</p> <table border="1"> <thead> <tr> <th rowspan="2">Construction Type</th> <th colspan="4">Stories</th> </tr> <tr> <th>1</th> <th>2</th> <th>3</th> <th>4</th> </tr> </thead> <tbody> <tr> <td>I(443)</td> <td>X</td> <td>X</td> <td>X</td> <td>X</td> </tr> <tr> <td>I(332)</td> <td>X</td> <td>X</td> <td>X</td> <td>X</td> </tr> <tr> <td>II(222)</td> <td>X</td> <td>X</td> <td>X</td> <td>X</td> </tr> <tr> <td>II(111)</td> <td>X</td> <td>X*</td> <td>X*</td> <td>NP</td> </tr> <tr> <td>II(000)</td> <td>X*</td> <td>X*</td> <td>NP</td> <td>NP</td> </tr> </tbody> </table>	Construction Type	Stories				1	2	3	4	I(443)	X	X	X	X	I(332)	X	X	X	X	II(222)	X	X	X	X	II(111)	X	X*	X*	NP	II(000)	X*	X*	NP	NP	K 056		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165274	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2015
NAME OF PROVIDER OR SUPPLIER WEST LIBERTY NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 774 LIBERTY ROAD WEST LIBERTY, KY 41472	
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K 056	Continued From page 5 III(211) X* X* NP NP III(200) X* NP NP NP IV(2HH) X* X* NP NP V(111) X* X* NP NP V(000) X* NP NP NP X: Permitted type of construction. NP: Not permitted. *Building requires automatic sprinkler protection. (See 19.3.5.1.)	K 056		

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185274	(Y2) Multiple Construction A. Building 01 - BUILDING B. Wing	(Y3) Date of Revisit 9/11/2015
Name of Facility WEST LIBERTY NURSING & REHABILITATION CENTER	Street Address, City, State, Zip Code 774 LIBERTY ROAD WEST LIBERTY, KY 41472	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0052	Correction Completed 09/11/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0056	Correction Completed 09/11/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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Reviewed By <input checked="" type="checkbox"/>	Reviewed By <i>JB/OK</i>	Date: 10-20-15	Signature of Surveyor: <i>Jerry Brush / AK</i>	Date: 10-20-15
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 8/20/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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