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

PRINTED: 09/08/2020 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE COI | (X3) DATE SURVEY COMPLETED | | | |
|--|---|---|--|--|------------------|--|--|
| | | 185408 | B. WING | | C 09/01/2020 | | |
| NAME OF PROVIDER OR SUPPLIER LIBERTY CARE AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETION | | |
| F 000 | a COVID-19 focus conducted on 09/0 unsubstantiated aridentified. The factompliance with 43 and has implement Medicaid Services Disease Control arecommended pra | andard survey (KY32214) and ed infection control survey was 11/2020. The complaint was and no deficient practice was sility was found to be in 2 CFR 483.80 Infection Control ated the Centers for Medicare & (CMS) and Centers for not Prevention (CDC) actices to prepare for otal census was 59. | F 000 | DEFICIENCY) | | | |
| LABORATORY | CORRECTORIS OF PROVIS | DER/SLIPPLIER REPRESENTATIVE'S SIGNATUR |) | TITLE | (X6) DATE | | |

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | ! | (X3) DATE SURVEY COMPLETED | |
|--|---|--|--|--|---|-------------------------------|--|
| | | 185408 | B. WNG | | | C | |
| NAME OF PROVIDER OR SUPPLIER LIBERTY CARE AND REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZI 616 S WALLACE WILKINSON BL LIBERTY, KY 42539 | | 09/01/2020 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH CORRECTIVE A CROSS-REFERENCED T | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| E 000 | survey was conducte facility was found to the CFR 483.73 Emerge | d Emergency Preparedness ed on 09/01/2020. The pe in compliance with 42 ncy Preparedness related to practice was identified. | E | 000 | | | |
| | | ω > | | | | | |
| | | VSLIDDI ICO DEDDESENTATIVE'S SIGMATI | | | | CALLAND | |

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: 09/08/2020 FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING_ 100685 09/01/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 616 S WALLACE WILKINSON BLVD LIBERTY CARE AND REHABILITATION CENTER LIBERTY, KY 42539 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 000 N 000 Initial Comments A complaint investigation (KY32214) and a COVID-19 focused infection control survey was conducted on 09/01/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE