

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

PRINTED: 03/26/2015  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186329	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/16/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  MORGANFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 599 NORTH CARRIER ST. MORGANFIELD, KY 42437
---	---

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

<p>F 000</p> <p>F 323 SS=D</p>	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey investigating #KY22932 was conducted on 03/12/15 through 03/16/15. #KY22932 was substantiated with a deficiency cited at a Scope and Severity of a "D".</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review it was determined the facility failed to provide adequate supervision prevent accidents for one (1) of (3) three sampled residents (Resident #1). Resident #1 was not able to be located for approximately one and one-half hour and was found in a locked therapy room which was under repair and had been left unlocked and unattended.</p> <p>A list provided by the Director of Nursing (DON) on 03/12/15 revealed there were eight (8) residents in the facility assessed as wandering residents and at risk for elopement.</p> <p>The findings include: Review of the facility's policy titled, "Resident Elopement Policy", not dated, revealed the</p>	<p>F 000</p> <p>F 323</p>	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegations by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within then (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this time frame should in no way be construed or considered as an agreement with the allegations of noncompliance or</p>	
------------------------------------	---	---------------------------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary G. Wood TITLE: Administrator (X6) DATE: 3/3/15

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.

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

PRINTED: 03/26/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185329	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/16/2015
NAME OF PROVIDER OR SUPPLIER  MORGANFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH CARRIER ST. MORGANFIELD, KY 42437		
(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)	(X6) COMPLETION DATE	
F 323	<p>Continued From page 1</p> <p>residents were assessed on admission to identify who was at risk for elopement. The admitting nurse was to determine appropriate interventions which may include the placement of a Wander-Guard in order to alert the staff of any attempt to elope from the facility. Further review revealed when a resident could not be located searches were conducted inside and outside the facility and appropriate notifications would be completed which included notification of Law Enforcement Organization (LEO) for missing persons.</p> <p>Record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses which included Dementia without behaviors, Congestive Heart Failure, and Anxiety. Review of a quarterly Minimum Data Set (MDS) assessment, dated 01/16/15 revealed the facility assessed Resident #1's cognition as severely impaired without a Brief Interview of Mental Status score of "00" which indicated the resident was not interviewable. The MDS further revealed the resident did not ambulate but was able to self propel him/herself in a wheelchair. Review of the Elopement/Wandering Risk Data Set, dated 12/28/15, revealed Resident #1 was assessed as at risk for elopement and was able to transport self independently by wheelchair and had poor safety/environment awareness.</p> <p>Interview with Registered Nurse (RN) #2, on 03/12/15 at 3:20 PM, revealed the staff was preparing to put Resident #1 to bed on 02/25/15 at approximately 9:00 PM and the resident could not be located. RN #2 stated her, Certified Nurse's Aide (CNA) #1, and CNA #2 searched inside and outside the facility and could not locate the resident. RN #2 revealed following the search</p>	F 323	<p>admission by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements</p> <p><b>F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b></p> <p>1) Resident #1 was placed on 15 minute checks on 2/25/15 by the Charge Nurse and was discontinued on 3/2/15. The Administrator completed an audit of the facility on 2/26/15 to identify any potentially unsafe areas that were not secured and to ensure all secured areas there was a key available to the staff. Any identified areas were secured and any areas that staff did not have access to a key was provided to the charge nurse. The construction crew was re-educated by the Administrator on 2/26/15 on ensuring that the therapy gym door was not propped</p>		

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

PRINTED: 03/26/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186329	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/16/2016
NAME OF PROVIDER OR SUPPLIER  MORGANFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH CARRIER ST. MORGANFIELD, KY 42437		
(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 2 of Hallway one (1), she alerted RN #3, RN #4 and Certified Nurse Aide (CNA) #3 that the resident could not be located. At that time, Hallway two (2) and all locked rooms the staff on duty were able to access were searched. RN #2 stated the staff checked the entire outside perimeter of the building, and a complete count of residents without success in finding Resident #1. RN #2 revealed she initiated the missing person procedure and notified the Administrator, the DON, the Clinical Reimbursement Coordinator (CRC), the local Law Enforcement Organization (LEO), the Resident's family and physician were notified. RN #2 stated the staff on duty did not know the combination to the therapy room lock and the keys were kept locked in the Administrator's office which was also locked and they did not have the key to access them. The DON arrived at approximately 10:15 PM, retrieved the keys from the Administrator's office and unlocked the therapy room door where Resident #1 was found. RN #2 revealed the therapy room was in the process of being renovated after a water pipe leak and a construction/painting crew had left the door propped open with a doorstop. RN #2 stated when the DON unlocked the therapy room door, she noted the room contained materials for replacing ceiling tiles covered with plastic sheeting in a corner and the therapy's stair climbing therapy steps were located in the opposite corner of the room. RN #2 revealed they had searched for the resident for approximately an hour and fifteen (15) minutes before they found him/her. RN #2 stated she had attempted to call the resident's son at 9:00 PM and the son called back around 10:00 PM. RN #2 revealed the son asked her if they had checked the therapy room as the resident liked to	F 323	open and was closed when they left for the day. The repairs to the therapy gym were completed on 3/17/15. 2) The Interdisciplinary team consisting of the Director of Nursing, Unit Manager, Assistant Director of Nursing, MDS Nurse, Social Services Director, Dietary Services Director and the Activity Director, completed audit of all current residents on 3-1-2015 to ensure that they had the appropriate level of supervision in place. No concerns were identified. The Administrator completed an audit of the facility on 2/26/15 to identify any potentially unsafe areas that were not secured and to ensure all secured areas there was a key available to the staff. Any identified areas were secured and any areas that staff did not have access to a key was provided to the charge nurse. The construction crew was re-		

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

PRINTED: 03/26/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185329	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/16/2015
NAME OF PROVIDER OR SUPPLIER  MORGANFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH CARRIER ST. MORGANFIELD, KY 42437		
(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 3</p> <p>go back there and either sit by the exit door and read or look outside; or go into the therapy room and read. RN #2 stated while she was on the phone with the resident's son the DON arrived and got the keys to the therapy room out of the Administrator's office, opened the therapy room door, and found the resident in the therapy room reading the newspaper.</p> <p>Interview on 03/13/15 with CNA #1 at 3:10 PM, CNA #2 at 4:20 PM and CNA #3 on 03/16/15 at 8:45 AM revealed they were working the evening shift on 02/25/15 when RN #2 initiated the elopement process for Resident #1 who could not be located. The CNA's stated they began searching the facility for the resident. CNA #1 stated he and CNA #3 searched outside the facility first then began searching the resident's rooms on Hall 1 and Hall 2 and all the bathrooms, shower rooms, the conference room and break room. CNA #1 revealed the only room inaccessible was the therapy room which no staff member on duty knew the combination nor had access to the key that was kept in the locked Administrator's office.</p> <p>Interview on 03/13/15 at 10:00 AM with RN #3 revealed she was working the evening shift of 02/25/15 when Resident #1 could not be located at 9:00 PM, so the elopement process was begun. RN #3 stated she printed a census and performed a head count of the residents during the search for Resident #1. RN #3 revealed all the resident rooms were double checked and the accessible locked rooms were opened and searched except the therapy room which no staff member on duty knew the combination nor had access to the key kept in the Administrator's office.</p>	F 323	<p>educated by the Administrator on 2/26/15 on ensuring that the therapy gym door was not propped open and was closed when they left for the day. The repairs to the therapy gym were completed on 3/17/15.</p> <p>3) The Administrator completed an audit of the facility on 2/26/15 to identify any potentially unsafe areas that were not secured and to ensure all secured areas there was a key available to the staff. Any identified areas were secured and any areas that staff did not have access to a key was provided to the charge nurse. The construction crew was re-educated by the Administrator on 2/26/15 on ensuring that the therapy gym door was not propped open and was closed when they left for the day. The repairs to the therapy gym were completed on 3/17/15. All facility staff were</p>		

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

PRINTED: 03/26/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186329	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/16/2015
NAME OF PROVIDER OR SUPPLIER  MORGANFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH CARRIER ST. MORGANFIELD, KY 42437		
(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 4  Interview on 03/13/15 at 4:05 PM with RN #4 revealed she was working the evening shift of 02/25/15 when RN #2 initiated the elopement process and all the staff in the facility searched for Resident #1. RN #4 stated the staff was unable to unlock the therapy room door because no one knew the combination and the key was kept in the Administrator's office. RN #4 revealed she was with the DON when the resident was found inside the therapy room which was under repair and was being painted.  Interview on 03/12/15 at 5:10 PM with Resident #1's son revealed he was notified the resident could not be located at approximately 9:00 PM on 02/25/15; however, due to poor cellular phone reception was not able to speak with the nurse until 10:00 PM when he inquired if the staff had checked in the therapy room since the resident liked to go into that room. He stated he was still on the phone with the nurse when Resident #1 was located in the therapy room by the DON.  Interview on 03/13/15 at 10:30 AM with the DON revealed she was notified of the inability to locate Resident #1 at approximately 9:45 PM on 02/25/15 by RN #2. The DON stated she arrived at the facility a little before 10:00 PM and asked the nursing staff if they had searched all the accessible areas inside the facility and a limited perimeter outside of the facility. The DON revealed the therapy room door was locked and no staff on duty knew the combination nor had access to the key kept in the Administrator's office and that locked room had not been searched. The DON stated at approximately 10:15 PM she unlocked the therapy room where the resident was located approximately five (5)	F 323	re-educated by the Administrator, Social Services Director and DON on the elopement policy. This was completed by 4/16/15.  4) The Administrator will complete a monthly audit of the facility to identify any potentially unsafe areas to ensure they are secured. The facility will conduct an elopement drill on each shift at least quarterly. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three months and then as concerns are identified. Anytime concerns are identified the Quality Assurance Committee will convene to review for further recommendations as needed. The QA committee will consist of at a minimum the Director of Nursing, Administrator, Social Services Director, Maintenance Director and Activity Director with the		

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

PRINTED: 03/26/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185328	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/16/2015
NAME OF PROVIDER OR SUPPLIER  MORGANFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 809 NORTH CARRIER ST. MORGANFIELD, KY 42437		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 5</p> <p>feet inside the room seated in her wheelchair reading a newspaper. The DON revealed staff would have to call her if there was a fire or a need to enter any locked rooms to include the therapy room.</p> <p>Interview on 03/13/15 at 10:00 AM with the Administrator revealed on 02/25/15 at approximately 10:10 PM the DON had notified her Resident #1 was missing, the staff had conducted searches of the facility and adjacent grounds and the local Police had been notified. The Administrator stated when she arrived at the facility at approximately 10:15 the DON unlocked the therapy room door and found the resident. The Administrator revealed the keys to the therapy room and other locked rooms and offices were kept locked in the administrator's office. The Administrator stated the therapy room was in the process of being renovated after a water pipe leak and a construction/painting crew had left the door propped open with a doorstop. The Administrator revealed she thought the resident had knocked the doorstop from the door and when going into the therapy room the door closed behind the resident locking him/her in the therapy room. Further interview revealed the Administrator stated staff would have to call the DON if there was a fire or a need to enter any locked rooms to include the therapy room.</p> <p>Interview on 03/16/15 at 9:15 AM revealed the local dispatcher for Law Enforcement Organization (LEO) received a call from the facility to notify of a missing resident on 02/25/15 at 10:16 PM and the LEO arrived on the scene at 10:21 PM, Officers were in the facility questioning the nurse when the resident was located in a locked therapy room.</p>	F 323	<p>Medical Director attending at least quarterly. Completion date is 4/16/15.</p>	4/16/15	

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

PRINTED: 03/26/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185329	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/16/2015
NAME OF PROVIDER OR SUPPLIER  MORGANFIELD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 508 NORTH CARRIER ST. MORGANFIELD, KY 42437		
(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