

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

PRINTED: 01/17/2012
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
JAN 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/29/2011
NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN STREET MORGANTOWN, KY 42261	
(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 An annual survey and an abbreviated survey (KY#17565 and KY#17566) was conducted on 12/27/11 through 12/29/11, and a Life Safety Code survey was conducted on 12/28/11. The facility failed to meet Federal requirements for recertification with deficiencies cited at the highest scope and severity of an "F." KY#17565 was unsubstantiated with no deficiencies and KY#17566 was substantiated with no deficiencies.	F 000	Morgantown Care and Rehab Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations or compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	1. Resident #5's care plan was updated on 12/28/11 to reflect the current Advanced Directive status. 2. A 100% audit of residents was completed by the Social Services Director on 12/29/11 to ensure residents care plans had been updated with the appropriate code status. No other concerns were identified.	2/1/12

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

Jeffrey Cleveland

TITLE

LVHA

(X6) DATE

1/26/12

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.

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F 279	<p>Continued From page 1</p> <p>by:</p> <p>Based on interview, record review and review of the facility's policy/procedure, it was determined the facility failed to review and revise the comprehensive care plan for one resident (#5), in the selected sample of 23. There was no evidence of a revised care plan related to advanced directives for Resident #5.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Advanced Directives," dated June 2007, revealed "the Care Plan Team will make such changes and/or revocations so that appropriate changes can be made in the resident assessment (MDS) and care plan. The Director of Nursing Services, Social Worker or designee will notify the attending physician of advance directives so that appropriate changes can be made in the resident assessment (MDS) and care plan."</p> <p>A record review revealed Resident #5 was admitted to the facility on 10/18/06 with diagnoses to include Coronary Artery Disease, Depression, Coronary Vascular Disease, Cerebral Vascular Accident, Hemiplegia, Seizures and Diabetes Mellitus.</p> <p>A review of the the resident's Advanced Directive revealed he/she was a full code status upon admission to the facility in 2006. Further review of the physician's orders, dated 10/27/11, revealed the family requested the resident be made a "Do Not Resuscitate"(DNR) status.</p> <p>A review of the significant change Minimum Data Set (MDS) assessment, dated 11/18/11, revealed</p>	F 279	<p>3. An in-service was provided on 1/13/12 to nursing staff by the Staff Development Coordinator regarding care plan update and revision. New orders will be reviewed by the Interdisciplinary Team in the daily clinical meeting to ensure care plans are updated and that they reflect current Advanced Directive status. The Social Services Director will complete a 10% monthly audit of residents to ensure care plans are updated and revised.</p> <p>4. Social Services Director will report findings of above stated audits to the Administrator and Quality Assurance Committee monthly for 3 months. A performance improvement plan and education will be initiated as indicated.</p>		

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F 279	Continued From page 2 the facility identified the resident to be cognitively impaired and required extensive assistance with activities of daily living (ADLs). A review of the resident's care plan for "Advanced Directives," dated 12/13/11, revealed the resident was a "Full Code" status. An interview with the Social Services Director (SSD), on 12/28/11 at 3:10 PM, revealed the resident's family chose a DNR status for Resident #5; however, the resident's care plan had not been revised to reflect that status. The SSD revealed she was responsible to ensure the Advanced Directives were accurate, and she stated a 10% audit was completed monthly. She revealed Resident #5's advance directives were reviewed on 12/13/11, and should have been changed from "Full Code" to "DNR" at that time.	F 279			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to provide services that met professional standards of quality for one resident (#20), in the selected sample of 23, and for one resident (#25), not in the selected sample. Observations of Resident #20 revealed his/her O2 was set at 1.5 liters per minute (LPM); however, review of the physician's order revealed the O2 was to be set at 5 LPM. Additionally, the	F 281	1. A physicians order was received on 12/28/11 for resident #20 to have Oxygen delivered at 2 liters per minute via nasal cannula. Resident #25's physician and family were notified of the medication time on 12/28/11.	2/1/12	

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F 281	<p>Continued From page 3</p> <p>facility failed to ensure one resident (#25) was administered medications as ordered. Observation during a medication pass, on 12/28/11, revealed Licensed Practical Nurse (LPN) #1 failed to administer medications to Resident #25 in a timely manner. The medications were ordered to be administered at 8:00 AM; however, the medications were not administered until 9:25 AM.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A review of the facility's policy/procedure, "Medication Administration-Administering Medications (Licensed Staff)," dated 12/2010, revealed "medications are administered only as ordered by the physician." A review of the "Medication Administration-Scheduled Times," dated 12/2010, revealed "all residents' medication administration records are on the Kardex or medication book. If medication is not administered at the designated time, the nurse will initial, circle and write on the back of the Medication Administration Record (MAR)/Treatment Administration Record (TAR) the reason for medication not being administered. Notify the physician as indicated." <p>A record review revealed Resident #25 was admitted to the facility on 08/11/09 with diagnoses to include History of Seizures, Alzheimer's Dementia, Hypertension and Hyperlipidemia.</p> <p>A review of the physician's orders, dated December 2011, revealed "Keppra (anticonvulsant) 500 milligrams (mg) one tablet twice daily (BID) for seizures" at 8:00 AM and 4:00 PM, and Namenda 10 mg one tablet twice</p>	F 281	<ol style="list-style-type: none"> 2. A 100% audit was completed on 12/28/11 for residents receiving Oxygen to ensure the amount of liters per minute was reflective of the current physician order. No other concerns were identified. A 100% audit of residents receiving meds during the medication pass was completed on 12/28/11 to ensure other meds were given within the appropriate time frame with no other concerns identified. 	

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F 281	<p>Continued From page 4</p> <p>daily (BID) for Alzheimer's" at 8:00 AM and 4:00 PM.</p> <p>Observation of the medication pass, on 12/28/11 at 9:25 AM, revealed LPN #1 administered Keppra 500 mg tablet and Namenda 10 mg tablet to Resident #25.</p> <p>An interview with LPN #1, on 12/28/11 at 10:15 AM, revealed she realized she was not in compliance with the time frame of administering medications. She stated she had one hour before or after the scheduled time to administer the residents' medications. LPN #1 revealed she did not usually have a problem administering medications within the appropriate time frame; however, she stated she did not normally work on the unit. LPN #1 stated she was "doing the best" she could do.</p> <p>An interview with the Director of Nursing (DON), on 12/29/11 at 10:00 AM, revealed the staff were expected to administer medications as ordered. The staff had one hour before or after the scheduled time frame to administer medications. If the staff had problems administering the medications within the appropriate time frame, they could ask their partner on the unit, call the Assistant Director of Nursing (ADON), or herself for assistance.</p> <p>2. A review of the facility's policy/procedure "Oxygen Administration," dated 12/2010, revealed "check physician's orders for liter flow and method of administration."</p> <p>A record review revealed Resident #20 was admitted to the facility on 03/04/11 with diagnoses</p>	F 281	<p>3. An in-service education was provided to the Respiratory Therapist by the Staff Development Coordinator on 12/28/11 regarding O2 and physician orders. In-service education was initiated on 12/28/11 by the Staff Development Coordinator to Licensed Nursing Staff regarding Oxygen administration reflecting what the physician order states. An in-service education was provided to Licensed Nursing Staff regarding medication administration and appropriate timeframe on 12/28/11 by the Staff Development Coordinator. The Respiratory Therapist will complete a 100% weekly audit to ensure O2 liters per minute are in compliance with the current physician order and report findings to the Director of Nursing. The Director of Nursing will complete a weekly medication administration audit to ensure timeframe compliance.</p>		

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NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN STREET MORGANTOWN, KY 42261	
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F 281	Continued From page 5 to include Coronary Artery Disease, Coronary Artery Bypass Graft, Anemia, Chronic Obstructive Pulmonary Disease and Asthma. The resident was placed on palliative care on 12/16/11 per the family's request. A review of a physician's order, dated 12/16/11 at 10:00 AM, revealed to administer oxygen (O2) at 5 liters per minute (LPM) per nasal cannula. Observations of the resident, on 12/27/11 at 11:35 AM and 3:55 PM, and on 12/28/11 at 10:35 AM, revealed administration of O2 per nasal cannula at 1.5 LPM. An interview with the Respiratory Therapist, on 12/28/11 at 10:35 AM, revealed the resident's O2 was set at 1.5 LPM; however, she thought the order was recently changed from 5 LPM to 1.5 LPM. An interview with the Director of Nursing (DON), on 12/28/11 at 11:10 AM, revealed it was nursing's responsibility to ensure the O2 was administered according to the physician's orders. No further explanation was provided.	F 281	4. The Director of Nursing will report findings of above stated audits to the Administrator and Quality Assurance Committee monthly for 3 months. A performance improvement plan and education will be initiated as indicated.	
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	F 315	1. A physicians order was received on 12/29/11 to remove resident #5's catheter. Resident #5's urinary status was reviewed with physician and a physician's order was received on 12/29/11 to remove resident #5's catheter. Foley catheter was removed with no complications.	2/1/12

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F 315	<p>Continued From page 6 function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure one resident (#5), in the selected sample of 23, received appropriate treatment and services related to the use of an indwelling urinary catheter without a diagnosis, and the failure to ensure the catheter tubing was appropriately anchored.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure "Catheter Care-Indwelling," dated 12/10, revealed "provide enough slack before securing the catheter to prevent tension on the tubing to avoid injuring the urethral lumen or bladder wall. Anchor the catheter to the resident's thigh to prevent possible tension on the urogenital area. Anchor the catheter to the (male) resident's thigh or lower abdomen to prevent pressure on the urethra at the penoscrotal junction."</p> <p>A record review revealed Resident #5 was admitted to the facility on 10/18/06 with diagnoses to include Cerebral Vascular Accident, Hemiplegia and Incontinence.</p> <p>Further record review revealed the resident was transferred to an acute care hospital on 10/03/11 with diagnoses to include pneumonia, and returned to the facility on 11/08/11 with an indwelling urinary catheter.</p>	F 315	<p>2. A 100% audit of residents with catheters was completed on 12/28/11 to ensure residents had an appropriate diagnosis. A 100% audit of residents with catheters was completed on 12/28/11 to ensure catheters were properly secured to avoid tension.</p> <p>3. An in-service was provided by Staff Development Coordinator to nursing staff and the Interdisciplinary Team on 1/4/12 regarding catheter use, appropriate diagnoses, and policy on proper anchoring of catheter tubing. A 100% audit of residents with catheters will be performed weekly for four weeks and then monthly by the Assistant Director of Nursing and the Staff Development Coordinator to ensure proper catheter anchoring and appropriate diagnosis for catheter use and report findings to the Director of Nursing. All new orders will be reviewed in the daily clinical meeting to ensure appropriate use of catheters with supporting diagnosis.</p>		

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F 315	<p>Continued From page 7</p> <p>A review of a significant change Minimum Data Set (MDS) assessment, dated 11/18/11, revealed the resident was cognitively impaired, incontinent of bowel and bladder, and required extensive assistance with activities of daily living (ADLs). Additional record review revealed there was no evidence of a diagnosis to support the use of the indwelling urinary catheter.</p> <p>An observation, on 12/28/11 at 8:30 AM, during a skin assessment completed by Registered Nurse (RN) #1, revealed the resident to have an indwelling urinary catheter. Further observation revealed the catheter tubing was not secured appropriately. An interview with RN #1, after completion of the resident's skin assessment, revealed indwelling urinary catheters were not routinely anchored, and during provision of care the urinary catheter tubing was to be moved with the resident.</p> <p>Further observations, on 12/28/11 at 9:00 AM and 11:30 AM, and on 12/29/11 at 8:30 AM, revealed the resident to have an indwelling urinary catheter to bedside drainage.</p> <p>An interview with the Director of Nursing (DON), on 12/28/2011 at 2:45 PM, revealed indwelling urinary catheters were utilized for residents with pressure sores that were above Stage II, or for residents diagnosed with urinary retention. She revealed that Resident #5 did not have a pressure sore, and could not provide evidence of a diagnosis of urinary retention.</p>	F 315	4. The Director of Nursing will report findings of above stated audits to the Administrator and Quality Assurance Committee monthly for 3 months. A performance improvement plan and education will be initiated as indicated.		

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1965, 1975</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200)</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Two (2) Type II generators. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 12/28/11. Morgantown Care and Rehab Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred twenty two (122) beds with a census of one hundred twelve (112) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>Morgantown Care and Rehab Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a wavier of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations or compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p>	

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

Jiffay Khan

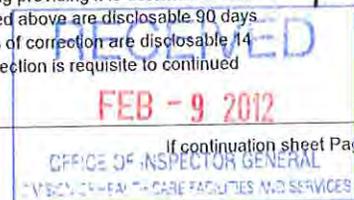
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K 000	Continued From page 1 Fire)	K 000		
K 018 SS=D	Deficiencies were cited with the highest deficiency identified at " F " level. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff, and visitors. The	K 018	1. The latch on door to room #228 was repaired and the bed in room #222 was moved to ensure proper latching of the door. 2. A 100% audit was completed by the Maintenance Director on 12/28/11 to ensure doors closed appropriately in accordance to K 018 and concerns were addressed as identified. 3. An in-service was provided on 1/19/12 to the Maintenance Director by the Regional Director of Plant Ops regarding proper door latching in accordance to K 018. The Maintenance Director will complete a 100% audit monthly to ensure door latching in accordance to K 018.	2/11/12



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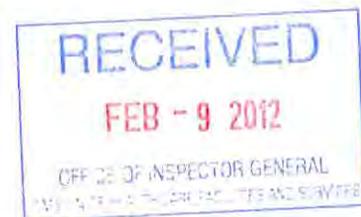
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K 018	<p>Continued From page 2</p> <p>facility is licensed for one hundred twenty two (122) beds with a census of one hundred twelve (112) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 12/28/11 between 10:30 AM and 5:00 PM, with the Maintenance Director revealed the corridor door to room #228 would not latch, and the door to room #222 was blocked from closing by the resident bed.</p> <p>Interviews, on 12/28/11 between 10:30 AM and 5:00 PM, with the Maintenance Director confirmed the observation of the doors not latching or closing due to being blocked by furniture.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and</p>	K 018	4. Maintenance Director will report findings of above stated audits to the Administrator and Quality Assurance Committee monthly for 3 months. A performance improvement plan and education will be initiated as indicated.	



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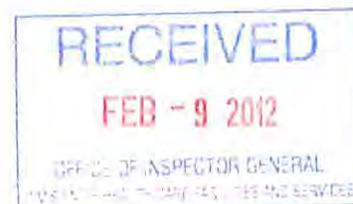
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K 018	Continued From page 3 similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1	K 029		



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K 029	Continued From page 4 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred twenty two (122) beds with a census of one hundred twelve (112) on the day of the survey. The findings include: Observation, on 12/28/11 at 2:45 PM, with the Maintenance Director revealed the door to the dry storage area in the Kitchen had been removed. Interview, on 12/28/11 at 2:45 PM, with the Maintenance Director revealed they were not aware the Dry Storage Room was considered a hazardous storage area. Reference:	K 029	1. A door was approved and ordered for the kitchen on 1/26/12. 2. A 100% audit was completed on 12/29/11 and 1/19/12 by the Maintenance Director on hazardous areas to ensure doors were in place in accordance to K 029. Concerns were addressed as identified. 3. An in-service was provided on 1/19/12 to the Maintenance Director by the Regional Director of Plant Ops regarding hazardous areas in accordance to K 029. A monthly audit will be completed by the Maintenance Director to ensure hazardous areas are in accordance with K 029. 4. Maintenance Director will report findings of above stated audits to the Administrator and Quality Assurance Committee monthly for 3 months. A performance improvement plan and education will be initiated as indicated.	2/11/12



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K 029	Continued From page 5 NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		



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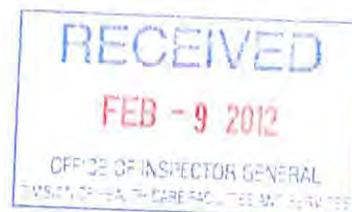
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K 038 SS=D	<p>Continued From page 6</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure means of egress in accordance with NFPA standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred twenty two (122) beds with a census of one hundred twelve (112) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/28/11 at 1:35 PM, with the Maintenance Director revealed the East Wing Exit did not have a durable surface to a public way.</p> <p>Interview, on 12/28/11 at 1:35 PM, with the Maintenance Director revealed he was not aware the exit needed a durable surface to a public way.</p> <p>Observation, on 12/28/11 at 2:25 PM, with the Maintenance Director revealed the exit in the Dining Room was blocked by a piano and a</p>	K 038	<ol style="list-style-type: none"> 1. Quotes were obtained on 1/23/12 and approved to place a durable surface to a public way on the East Wing Exit. The concrete is scheduled to be placed on 2/2/12. The piano and decorative tree were removed from the exit. 2. A 100% audit was completed on all exits and findings were addressed as indicated. 3. In-service education was provided to the on 1/19/12 to the Maintenance Director by the Regional Director of Plant Ops exit pathways and surfaces. A weekly audit will be performed by the Maintenance Director for 4 weeks, then monthly for 2 months to ensure exits are free from obstructions. 4. Maintenance Director will report findings of above stated audits to the Administrator and Quality Assurance Committee monthly for 3 months. A performance improvement plan and education will be initiated as indicated. 	2/11/12



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K 038	Continued From page 7 decorative tree. Interview, on 12/28/11 at 2:25 PM, with the Maintenance Director revealed he was not aware the items had been placed so close to the exit doors. Reference: NFPA 101 (2000 Edition). 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 038		
K 072 SS=E	CMS Ref: S&C-05-38 NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The	K 072	1. Linen carts, lifts, trash carts, and wheelchairs were removed from hallways when not in use.	2/11/12



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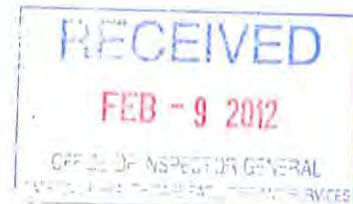
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K 072	Continued From page 8 deficiency had the potential to affect five (5) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred twenty two (122) beds with a census of one hundred twelve (112) on the day of the survey. The findings include: Observation, on 12/28/11 between 10:30 AM and 5:00 PM, with the Maintenance Director revealed linen carts, lifts, trash carts, and wheelchairs were being stored in the corridors of the South Wing, East Wing, IC1 Hall, and the Skilled Hall. The Skilled Hall is located in the basement. Interview, on 12/28/11 between 10:00 AM and 5:00 PM, with the Maintenance Director revealed the facility routinely stored linen carts, lifts, trash carts, and wheelchairs in these halls. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	2. In-service education was provided on 1/26/12 to all staff by the Maintenance Director and Staff Development Coordinator regarding storage of linen carts, lifts, trash carts, and wheelchairs in appropriate designated areas when not in use to free the means of egress of obstructions. 3. A weekly audit will be performed by the Maintenance Director for 4 weeks, then monthly for 2 months to ensure items are not stored in corridors when not in use. 4. Maintenance Director will report findings of above stated audits to the Administrator and Quality Assurance Committee monthly for 3 months. A performance improvement plan and education will be initiated as indicated.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than	K 076	1. Oxygen tanks were moved to a concrete block room on 12/29/11. It has a one hour separation and no combustible items are stored in this room.	2/11/12



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K 076	Continued From page 9 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored in accordance with NFPA standards. This deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred twenty two (122) beds with a census of one hundred twelve (112) on the day of the survey. The findings include: Observation, on 12/28/11 at 4:35 PM, with the Maintenance Director revealed an excess of 12 oxygen tanks were stored within five (5) feet of combustible materials located in the oxygen storage room. There was no signage indicating full or empty tanks. Interview, on 12/28/11 at 4:35 PM, with the Maintenance Director revealed he was not aware combustible material could not be stored within five (5) feet of the oxygen tanks. Reference: NFPA 99 (1999 edition) 8-3.1.11.2 Storage for nonflammable gases greater than	K 076	2. A 100% audit was completed in facility with no other oxygen tanks stored within five feet of combustible materials. 3. An in-service was provided by the Administrator on 12/29/11 to the Maintenance Director and Central Supply Director regarding the proper storage of oxygen tanks. The Maintenance Director will complete a weekly audit for 4 weeks, then monthly for 2 months to ensure proper storage of oxygen tanks. 4. Maintenance Director will report findings of above stated audits to the Administrator and Quality Assurance Committee monthly for 3 months. A performance improvement plan and education will be initiated as indicated.	



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K 076	Continued From page 10 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.	K 076		
K 144 SS=F	8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		



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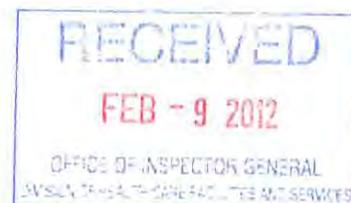
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K 144	<p>Continued From page 11</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred twenty two (122) beds with a census of one hundred twelve (112) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/28/11 at 5:00 PM, with the Maintenance Director revealed the facility was equipped with a total of two (2) emergency generators. The generators are not equipped with an annunciation panel to make staff aware of alarm conditions with the generators.</p> <p>Interview, on 12/28/11 at 5:00 PM, with the Maintenance Director revealed they were not aware of the location of the annunciation panel. A call from the facility to Fesco Fire Suppression revealed the generators were wired into the Fire Alarm Control Panel and would report Generator Run, and Generator Fails as stated in a letter from Fesco to the facility dated December 29, 2011. However, the letter from Fesco to the facility does not state how the FACP reports these</p>	K 144	<ol style="list-style-type: none"> Parts are due to be shipped to Nixon Power Services on 2/10/12 and installation of the enunciator panel in accordance to K 144 is scheduled for 2/12/12. Weekly generator test are performed by the Maintenance Director. This test includes checking battery, oil level, test under load, run time of generator, simulated power failure, and voltage output. No concerns were identified in the weekly generator tests. The Regional Plant Ops Director in-serviced the Administrator and Maintenance Director on 1/26/12 regarding the appropriate enunciator panel in accordance to K 144. The maintenance director will report findings of weekly generator tests to the Administrator and report to the Quality Assurance Committee monthly for 3 months. A performance improvement plan and education will be initiated as indicated. 	<p>2/11/12 2-13-12 Per Tiffany Clark by PB 2-9-12</p> <p>2-17-12 Per Tiffany Clark Adm.</p> <p>by PB 2-13-12</p>



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185006	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/28/2011
NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN STREET MORGANTOWN, KY 42261	
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K 144	Continued From page 12 conditions, and does not address other conditions of the emergency power source in accordance with NFPA standards. Reference: NFPA 99 (1999 Edition). 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but	K 144		



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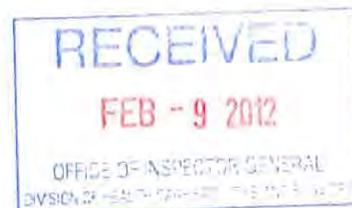
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K 144	Continued From page 13 need not display these conditions individually. [110: 3-5.5.2]	K 144		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred twenty two (122) beds with a census of one hundred twelve (112) on the day of the survey. The findings include: Observation, on 12/28/11 between 10:30 AM and 5:00 PM, with the Maintenance Director revealed: 1) A power strip plugged into an extension cord powering three (3) soap dispensing units to the Laundry Room washers. 2) An air pump plugged into a power strip located in room #16. 3) A ceiling light fixture with no cover had a light bulb socket broken and hanging by the wires located in the South Wing Linen Room. 4) A power strip plugged into another power strip located in the Admissions Office and the Business Office.	K 147	1. The extension cord and power strip was removed from the laundry area on 1/5/12. The power strip was removed from room #16 on 12/29/12. The light fixture in the south wing linen room was repaired on 1/3/12. The second power strips were removed from the Admissions and Business offices on 1/24/12. The power strip and extension cord was removed from the east wing copy room on 1/23/12. The power strip was removed from the ICII Med Room and the refrigerator and air unit were plugged directly into the outlet on 12/30/11. The extension cord was removed from the fish pond and ICII med room on 12/30/11. The power strip and extension cord were removed from the kitchen on 1/18/12.	2/11/12



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K 147	Continued From page 14 5) A power strip plugged into an extension cord located in the East Wing Copy Room. 6) A refrigerator and a window air conditioning unit were plugged into a power strip located in the IC2 Med Room. Further observation of the IC2 Med Room revealed an extension cord plugged into the same power strip running out the window to the fish pond pump in the court yard. 7) The convection oven in the Kitchen was plugged into an extension cord that was plugged into a power strip along with the coffee pot. 8) An extension cord type wire was run through the wall to the outside of the Kitchen to an air curtain unit. 9) A suction pump and a breathing machine were plugged into a power strip located in room #114. 10) A refrigerator was plugged into a power strip located in the Medical Records Office. Interview, on 12/28/11 between 10:30 AM and 5:00 PM, with the Maintenance Director revealed he was not aware of the extension cords and power strips being misused. Further interview revealed he was also not aware of the broken light fixture. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the	K 147	The extension cord was removed from the kitchen air curtain on 1/18/12. The power strip was removed from room #114 and the suction pump and breathing machine were plugged directly into the outlet on 12/30/11. The power strip was removed from the Medical Records office on 1/17/12. 2. A 100% walk-through audit was completed by the Maintenance Director on 12/29/11 to identify any areas with the use of an extension cord or power strip. All concerns were address as identified.	



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K 147	Continued From page 15 intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	<p>3. The Maintenance Director provided an in-service to department managers on 12/29/11 regarding the use of power strips and extension cords. An in-service will be provided to all staff regarding the use of extension cords and power strips in accordance to K 147 by the Staff Development Coordinator on 1/27/12. The maintenance director will perform a 100% audit in the facility to ensure no extension cords are present and the appropriate use of receptacles in accordance to K 147. This audit will be complete monthly for 3 months and quarterly thereafter.</p> <p>4. The maintenance director will report findings of weekly generator tests to the Administrator and report to the Quality Assurance Committee monthly for 3 months. A performance improvement plan and education will be initiated as indicated.</p>	

