

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

PRINTED: 10/14/2013
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 R 09/30/2013
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 000}	INITIAL COMMENTS Based upon implementation of the acceptable PoC, the facility was deemed in compliance, 09/30/13 as alleged.	{F 000}			

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

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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NAME OF PROVIDER OR SUPPLIER MORGANFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH CARRIER ST. MORGANFIELD, KY 42437
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F 000	INITIAL COMMENTS	F 000		
F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy and procedure review, the facility failed to ensure adequate oxygenation during tracheostomy (trach) care for one (1) resident (#9), in the selected sample of fifteen (15) residents. Observation of tracheostomy care for Resident #9 revealed the licensed staff failed to provide 100% oxygen (O2) before and after suctioning and during trach care.</p> <p>The findings include: Interview Registered Nurse (RN) #1, on 08/15/13 at 1:15 PM, revealed the facility used the</p>	F 328	<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 allegation 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 ten (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</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Mary L Wood* TITLE: *Admin* (X6) DATE: *9/6/13*

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 328	<p>Continued From page 1</p> <p>Lippincott Manual of Nursing Practices as their policy and procedure for tracheostomy care and suctioning.</p> <p>A review of the Lippincott Manual of Nursing Practices, Eighth Edition, dated 2006, revealed licensed staff should provide 100% oxygen before and after suctioning and during trach care if the resident is oxygen dependent to prevent hypoxia.</p> <p>A record review revealed Resident #9 was admitted to the facility on 01/26/11 with diagnoses to include Pneumonia and Tracheostomy with Chronic Respiratory Failure. A review of the quarterly Minimum Data Set (MDS) assessment, dated 07/24/13, revealed the facility assessed Resident #9's cognition as severely impaired, requiring oxygen (O2), suctioning and trach care.</p> <p>A review of the Comprehensive Care Plan for Attention to Tracheostomy, dated 08/12/12, revealed an intervention to provide tracheostomy care every shift.</p> <p>A review of the physician orders, dated 09/22/11, revealed the physician ordered O2 at three (3) liters per minute (lpm.) at 40% humidity, suctioning every shift and as needed.</p> <p>An observation of Registered Nurse (RN) #3 providing trach care for Resident #9, on 8/15/13 at 4:00 PM, revealed the initial O2 saturation (sat.) level before care was 98%, heart rate was 66 beats per minute (bpm) and the pulse signal indicator reading was strong. Observation of the resident's O2 revealed the resident was receiving O2 at two (2) lpm at 31% with humidity.</p> <p>Interview with RN #3, on 8/15/13 at 4:05 PM,</p>	F 328	<p>should in no way be construed or considered as an agreement with the allegations of noncompliance or admission by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p> <p>F 328 TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>1) On August 15, 2013, a contract Respiratory Therapist evaluated resident # 9 and made recommendations for oxygen set up. The physician for resident #9 was notified on August 15, 2013 and orders obtained for a new oxygen set up which were implemented and validated by the Director of Nursing to be per physician order on August 15, 2013. The Respiratory Therapist provided training to the Director of Nursing, Assistant Director of</p>		

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F 328	<p>Continued From page 2</p> <p>revealed a different Venturi device was needed to achieve 40% O2 and the liter flow needed was eight (8) lpm.</p> <p>A review of the AirLife Manufacturers Instructions for product #D01255 revealed to achieve 40% oxygen concentration, a liter flow rate of 8 lpm must be utilized.</p> <p>Further observation of the trach care revealed RN #3 obtained a different Venturi device and changed the Venturi to 40% at 3 lpm and stated she would contact the doctor to obtain an order for the required eight (8) lpm per manufacturer's recommendations. The RN then removed the inner cannula from the trach and placed it into the solution on the trach care tray and prepared for suctioning. The RN removed the O2 from over the trach and proceeded to suction the resident. After one (1) pass, the RN stated the resident didn't need to be suctioned again. Resident #9 began to spontaneously cough becoming extremely red faced and cyanotic in the face and lips. It was noted that the resident had an increase use of accessory muscles. The resident was not receiving any O2 at this time. The RN proceeded to clean the trach cannula, then re-inserted it back into the resident's trach tube and replaced the O2 over the trach tube. The resident's O2 saturation level was 89% and the heart rate was 62 bpm with the pulse signal indicator reading strong. O2 sats increased to 91% with a heart rate of 69 after O2 was reapplied for two (2) minutes.</p> <p>An interview with RN #3, on 08/16/13 at 1:47 PM, revealed she had not received any training at this facility related to suctioning and trach care. The RN stated the facility knew she had experience</p>	F 328	<p>Nursing and the Director of Education and Training. The Director of Nursing observed staff providing suction and tracheostomy care on August 19, 2013 and noted that staff provided the appropriate level of re-oxygenation before and after suctioning and during tracheostomy care with resident # 9's oxygen saturations remaining above ninety (90) percent.</p> <p>2) The Director of Nursing observed staff providing suction and tracheostomy care on all residents with a tracheostomy on August 19, 2013 and noted that staff provided the appropriate level of re-oxygenation before and after suctioning and during tracheostomy care. No concerns were identified.</p> <p>3) All Licensed Nurses will be re-educated by a contract Respiratory Therapist by 9-29-2013 on the proper technique for tracheostomy</p>	

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F 328	Continued From page 3 with trachs at other facilities. An interview with Resident #9's attending Physician, on 8/16/13 at 1:50 PM revealed he was unaware of this happening and stated that this was not an unacceptable practice and expected RN #3 to maintain care set forth by his/her orders. An interview with the Facility's Medical Director, on 8/16/13 at 2:10 PM, revealed he visited Resident #9 in the past and had not noticed any complications. The physician stated he expected RN #3 to comply with clinical guidelines.	F 328	suction and tracheostomy care. No Licensed Staff will work past 9-29-2013 without having had received this re-education by the Respiratory Therapist or a Licensed Nurse deemed competent by the Respiratory Therapist.		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	4) The Director of Nursing, Assistant Director of Nursing or Education and Training Director will observe the tracheostomy care to assure that tracheostomy care is provided three (3) times per week for twelve (12) weeks. These observations will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time the concerns are identified, the facility will convene a Quality Assurance Committee meeting to review for further recommendations as needed. The Quality Assurance Committee will		

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F 425	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, policy review and record review, the facility failed to ensure medication was properly stored, counted and disposed of properly, related to an opened multidose vial of Ativan in the medication refrigerator. The findings include: An observation of the Medication Storage Rooms, on Hall Two (2,) on 08/15/13 at 1:30 PM, revealed an uncapped, unlabeled, undated, multi-dose vial of Ativan 2 milligrams (mg) in 1 milliliter (ml,) with a puncture hole in the rubber stopper. An interview with Licensed Practical Nurse (LPN) #1, on 08/15/13 at 1:40 PM, revealed there were no residents with a prescription for Ativan, as an Intramuscular (IM) Injection. The only other Ativan, in the vial, was in the locked Emergency Drugs Kit (EDK,) and this was in the kit and correct with the par value established, of one vial. The LPN also stated the Ativan found in the refrigerator, was not counted on the Narcotic Count Sheet. A second interview with LPN #1, on 08/15/13 at 2:20 PM, revealed unsampled Resident #22 had received a one time dose of Ativan IM, on 08/11/13, for agitation and combativeness, after several interventions had been attempted. The LPN stated the rest of the vial should have been wasted and not placed back in the refrigerator. An interview with LPN #2, on 08/15/13 at 4:43 PM, revealed Resident #22, with a diagnosis of	F 425	consist of at a minimum the Director of Nursing, the Assistant Director of Nursing, the Social Service Director, and the Administrator with the Medical Director attending at least quarterly. 5) Correction date is 9/30/2013 F 425 PHARMACEUTICAL SVC- ACCURATE PROCEDURES 1) The identified vial of Ativan was disposed on ??? as observed by the Director of Nursing. 2) On August 19, 2013, the Director of Nursing noted that all narcotics were stored properly and counted per policy. No concerns were identified. 3). All licensed staff will be re-educated by the Education and Training Director, Director of Nursing or the Assistant Director of Nursing related to the counting, storing and destruction of Narcotics in the locked Narcotics Box.	9/30/13

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F 426	Continued From page 5 Bipolar Disorder, had experienced agitation that escalated to combativeness, after a family visit and not being allowed to go home with the family member and the physician was notified. An order was given for Ativan 0.5 ml, IM, a one time dose, was given from the EDK. The pharmacy was called to replace the medication and advised the LPN to "hold on to the other dose for 24 hours, just in case we might need it." The LPN stated she would normally waste the dose, per facility policy. However, the LPN notified the oncoming shift of the Ativan and was told they would take care of this. The Ativan remained in the refrigerator for four more days, without being counted or wasted. An interview with the DON, on 08/15/13 at 4:40 PM, revealed she would have expected the staff to have wasted the Ativan and had another staff member to witness this.	F 426	Education and training will be completed by September 29, 2013 with no licensed staff working after this date without having received this re-education. 4) The Director of Nursing, Assistant Director of Nursing or the Education and Training Director will audit the locked narcotic box weekly for twelve (12) weeks to ensure that narcotics are counted and destroyed per guidelines. These observations will be reviewed with the Quality Assurance Committee for three (3) months and if any concerns are identified, the facility will convene a Quality Assurance Committee meeting to review for further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, the Assistant Director of Nursing, the Social Service Director, and the Administrator with the Medical Director attending at least quarterly. 5) Correction date is September 30, 2013.	9/30/13	



consist of at a minimum the Director of Nursing, the Assistant Director of Nursing, the Social Service Director, and the Administrator with the Medical Director attending at least quarterly.

- 5) Correction date is 9/30/2013

**F 425 PHARMACEUTICAL
SVC- ACCURATE
PROCEDURES**

- 1) The identified vial of Ativan was disposed on 8/15/2013, as observed by the Director of Nursing.
- 2) On August 19, 2013, the Director of Nursing noted that all narcotics were stored properly and counted per policy. No concerns were identified.
- 3). All licensed staff will be re-educated by the Education and Training Director, Director of Nursing or the Assistant Director of Nursing related to the counting, storing and destruction of Narcotics in the locked Narcotics Box.

this date without having received this re-education.

- 4) The Director of Nursing, Assistant Director of Nursing or the Education and Training Director will audit the locked narcotic box weekly for twelve (12) weeks to ensure that narcotics are counted and destroyed per guidelines. These observations will be reviewed with the Quality Assurance Committee for three (3) months and if any concerns are identified, the facility will convene a Quality Assurance Committee meeting to review for further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, the Assistant Director of Nursing, the Social Service Director, and the Administrator with the Medical Director attending at least quarterly.
- 5) Correction date is September 30, 2013.

9/30/13

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{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 09/30/2013 as alleged	{K 000}			

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

TITLE

(X6) DATE

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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.</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: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1992, with 19 smoke detectors and no heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1966 and upgraded in 1998.</p> <p>GENERATOR: (2) Type II generators installed in 2009. Fuel source is Liquid Propane.</p> <p>A standard Life Safety Code survey was conducted on 08/13/13. Morganfield Nursing and Rehab was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Sixty (60) beds with a census of Fifty-Three (53) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<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 allegation 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 ten (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</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Mary L. Wood* TITLE *Administrator* (X6) DATE *9/16/13*

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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000	should in no way be construed or considered as an agreement with the allegations of noncompliance or admission by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.		
K 025 SS=E	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.6, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and Interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty (60) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure one (1) smoke barrier was sealed around pipes and wires to resist the passage of smoke and one barrier had access to check the condition of the barrier. The findings include:	K 025	K025 1. The identified one (1) smoke barrier that was not sealed around pipes/wires and access to check condition of the barrier will be repaired by 9/29/2013 by a contractor. The access to the barrier at room # 35 will be installed by contractor by 9/30/13. 2. On 8/29/13, the Maintenance Director and a contractor audited the entire facility to identify any smoke barriers with penetrations and access for barrier at room #35. All identified areas will be repaired by 9/30/13. 3. The Maintenance Director was re-educated by the Administrator on the Life Safety Code for fire and		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 08/23/2013
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2013
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NAME OF PROVIDER OR SUPPLIER MORGANFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH CARRIER ST. MORGANFIELD, KY 42437
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	<p>Continued From page 2</p> <p>Observations, on 08/13/13 at 12:15 PM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling, located in the laundry area was penetrated by pipes and wires. Further observation revealed the barrier at room #36 did not have access to check the condition of the barrier.</p> <p>Interview, on 08/13/13 at 12:16 PM with the Maintenance Supervisor, revealed he was unaware of the penetrations in the smoke barrier at the laundry. The facility hired an outside contractor to repair all the smoke barriers and they must have missed that one.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration</p>	K 025	<p>smoke walls. This education was completed on 8/30/13.</p> <p>4. The Maintenance Director will audit fire and smoke walls to assure there are no penetrations monthly for three (3) months and then at least quarterly thereafter. The results of the audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at least the Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director and the Medical Director attending at least quarterly.</p> <p>5. Completion date 9/30/13.</p> <p>K 027</p> <p>1. The cross-corridor doors located at the front of hall 1 and hall 2 will have modifications done to ensure that the door coordinators are working properly. These</p>	9/30/13

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K 025	Continued From page 3 Into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose. NFPA 101 LIFE SAFETY CODE STANDARD	K 025	modifications will be done by 9/29/13. 2. An audit of all other cross corridor smoke doors was completed by the Administrator on 9-6-2013 to assure that all closed appropriately and resisted the passage of smoke. No concerns were identified. 3. The Administrator will re-educate the Maintenance Director on the requirement that the cross corridor doors located in a smoke barrier would resist the passage of smoke and close appropriately. This education was completed on 8/30/13.	
K 027 SS=F	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would	K 027	4. The Maintenance Director will audit all cross corridor doors to assure that doors close appropriately and resist the passage of smoke monthly for three (3) months. The results of the audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality	

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K 027	<p>Continued From page 4</p> <p>resist the passage of smoke in accordance with NFPA standards The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty (60) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure the cross corridors doors would close properly with the installed door coordinators.</p> <p>The findings include:</p> <p>Observation, on 08/13/13 at 12:15 PM with the Maintenance Supervisor, revealed the cross-corridor doors located at the front of the hall 1 and the front of hall 2 would not close completely when tested. This was due to the door coordinators not working properly.</p> <p>Interview, on 08/13/13 at 12:15 PM with the Maintenance Supervisor, revealed the coordinators were recently installed and he was not aware they were not working properly.</p> <p>Reference: NFPA 101 (2000 Edition), 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.</p> <p>Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices, 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of</p>	K 027	<p>Assurance Committee will consist of at least the Administrator, Director of Nursing, Assistant Director, Maintenance Director with the Medical Director attending at least quarterly.</p> <p>5. Completion date: 9/30/13.</p> <p>K048</p> <ol style="list-style-type: none"> 1. The Administrator will ensure that facility's Fire Safety Plan and Procedure Policy address the evacuation of a smoke compartment. The Fire Safety Plan and Procedure Policy will be in place by 9/29/13. 2. The Administrator will ensure that facility's Fire Safety Plan and Procedure Policy address the evacuation of a smoke compartment. The Fire Safety Plan and Procedure Policy will be in place by 9/29/13. 3. On 8/30/13, the Administrator re-educated the Maintenance Director on the requirement that the facility's Fire Safety Plan and Procedure Policy addresses the evacuation of a smoke compartment. All facility staff will be re-educated on the facility fire safety policy including evacuation 	9/30/13
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K 048	<p>Continued From page 6</p> <p>Interview, on 08/13/13 at 1:21 PM with the Maintenance Supervisor, revealed he was unaware the smoke compartment evacuation was not included on the fire safety plan. The facility does practice this during fire drills.</p> <p>Actual NFPA Standard: 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every healthcare occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator's position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.</p>	K 048	<p>end will be moved to be located within five (5) feet of the exit door.</p> <p>2. On 8/30/13, the Maintenance Director audited the entire facility to identify any manual pull stations that were not within five (5) feet of an exit door. Any identified concerns will be corrected by 9/29/13.</p> <p>3. The Maintenance Director was re-educated by the Administrator on the NFPA standards that manual pull stations need to be located within five (5) feet of an exit door. The education was completed by 8/30/13.</p> <p>4. The Maintenance Director will audit all the manual pull stations to ensure that location is within NFPA guidelines monthly for three (3) months. The results of the audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at least the Administrator,</p>	
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K 048	Continued From page 7 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 19.7.2 Procedure in Case of Fire. 19.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy's fire safety plan. 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire 19.7.2.3 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions: (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system	K 048	Director of Nursing, Assistant Director of Nursing and the Maintenance Director with the Medical Director attending at least quarterly. 5. Completion date: 9/30/13 K 056 1. The two (2) shower rooms in facility will have proper sprinkler protection in the rooms to cover the three (3) stalls in the shower rooms. This was verified by the Maintenance Director on 8/30/13. 2. Armor Fire Protection will do a complete facility wide audit by 9/29/13 and locate any and all sprinkler heads that do not cover the area of protection. All identified concerns will be corrected by 9/29/13. 3. The Administrator re-educated the Maintenance Director on 8/30/13 on the Life Safety code for placement and spray of sprinkler heads. 4. The Maintenance Director will audit all sprinkler heads to ensure they are located to provide coverage and spray to assigned areas monthly for three (3) months. The results of the audits will be	9/30/13

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K 048	Continued From page 8	K 048	reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at least the Administrator, Director of Nursing, Assistant Director of Nursing and the Maintenance Director with the Medical Director attending at least quarterly.	
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building fire alarm system was installed as	K 051	5. Completion date: 9/30/13 K 066 1. Proper ashtrays with proper self-closing lids and a self-closing metal container to dump ashtrays into are now readily available at the smoker's porch as observed by the Administrator on 9/9/13. 2. All smoking areas were audited by the Maintenance Director on 8/30/13 to assure they had approved ashtrays and ashtray metal disposal containers with self closing lids. Smoking devices that do not meet standards were	9/20/13

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K 051	<p>Continued From page 9</p> <p>required by NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, thirty (30) residents, staff and visitors. The facility is certified for Sixty (60) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure the one (1) exit had a manual fire alarm pull station located within 5 feet.</p> <p>The findings include:</p> <p>Observation, on 08/13/13 at 2:31 PM with the Maintenance Supervisor, revealed the exit on hall 1 east end did not have a manual pull station located within 5 feet of the exit door.</p> <p>Interview, on 08/13/13 at 2:31 PM with the Maintenance Supervisor, revealed he was unaware of the requirement to have the pull station within 5' of an exit door and did not know why this one door had it 10' from the door.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.4.2* Initiation. Initiation of the required fire alarm systems shall be by manual means in accordance with 9.6.2 and by means of any required sprinkler system waterflow alarms, detection devices, or detection systems.</p> <p>Exception No. 1: Manual fire alarm boxes in patient sleeping areas shall not be required at exits if located at all nurses' control stations or other continuously attended staff location, provided that such manual fire alarm boxes are visible and continuously accessible and that travel distances required by 9.6.2.4 are not exceeded.</p>	K 051	<p>removed and no longer used per the Maintenance Supervisor on 9/9/13.</p> <p>3. The Maintenance Director will be re-educated by the Administrator on the requirement that metal containers with self-closing cover devices into which ashtrays can be emptied are readily available. This re-education will be completed by 9/10/13.</p> <p>4. The Maintenance Supervisor will continue to monitor smoking area on a monthly basis for three (3) months. The results of the audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at least the Administrator, Director of Nursing, Assistant Director of Nursing and the Maintenance Director with the Medical Director attending at least quarterly.</p> <p>5. Completion date: 9/30/13.</p>	9/30/13	

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K 056 SS=E	<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 complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty (60) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure two (2) shower rooms were properly sprinkler protected.</p> <p>The findings include:</p> <p>Observation, on 08/13/13 at 1:45 PM with the Maintenance Supervisor, revealed the two (2) shower rooms in the facility did not have proper sprinkler protection in the rooms to cover the three stalls in the shower rooms.</p> <p>Interview, on 08/13/13 at 1:45 PM with the</p>	K 056	<p>K 072</p> <ol style="list-style-type: none"> 1. All items in the lobby area were moved to assure that there was a clear unobstructed path to the means of egress as observed by the Administrator on 9-6-2013. 2. The Maintenance Director will audit all means of egress to assure all have a clear unobstructed path to the means of egress by 9-29-2013. Any identified concerns will be immediately corrected. 3. The Maintenance Director was re-educated by the Administrator on the means of egress shall be continuously maintained free of obstructions or impediments. The education was completed on 8/30/13. 4. The Maintenance Director will audit the lobby egress to assure that the egress is free of obstructions or impediments monthly for three (3) months and then at 	

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K 056	Continued From page 11 Maintenance Supervisor, revealed he had never noticed the position of the sprinkler head and confirmed the sprinkler in the room would not cover the three stalls in the shower rooms. Reference: S&C 09-04 Adoption of New Fire Safety Requirements for Long Term Care Facilities, Mandatory Sprinkler Installation Requirement http://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter09-04.pdf	K 056	least quarterly thereafter. The results of the audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at least the Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, with the Medical Director attending at least quarterly. 5. Completion date: 9/30/13.	9/30/13	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066			

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K 066	Continued From page 12 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for Sixty (60) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure they had a self-closing metal container to dump ashtrays into at the smoking area and improper ashtrays were in use at the area. The findings include: Observation, on 08/13/13 at 3:45 PM with the Maintenance Supervisor, revealed the smoking area did not have a metal container with a self-closing lid to dispose of the cigarette butts. Further observation revealed there were two (2) improper ashtrays in use with no self-closing lids. Interview, on 08/13/13 at 3:45 PM with the Maintenance Supervisor, revealed he was unaware of the requirement for the metal bucket and he did not know where the two (2) improper ashtrays had come from. Reference: NFPA Standard 101 (2000 Edition). 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room,	K 066		

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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: 185329	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2013
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NAME OF PROVIDER OR SUPPLIER MORGANFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH CARRIER ST. MORGANFIELD, KY 42437
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K 066	Continued From page 13 ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		
K 072 SS=E	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	K 072		

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NAME OF PROVIDER OR SUPPLIER MORGANFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH CARRIER ST. MORGANFIELD, KY 42437
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K 072	<p>Continued From page 14</p> <p>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 deficiency had the potential to affect two (2) of four (4) smoke compartments, thirty (30) residents, staff and visitors. The facility is certified for Sixty (60) beds with a census of Fifty-Three (53) on the day of the survey. The facility failed to ensure a lobby area was placed in an egress path without following the 2012 edition of life safety code.</p> <p>The findings include:</p> <p>Observation, on 08/13/13 at 2:03 PM with the Maintenance Supervisor, revealed tables, flag pole, bookshelf, fireplace, fish tank, showcase, and lounging chairs were stored at the front exit of the facility to make a lobby area in the egress path.</p> <p>Interview, on 08/13/13 at 2:03 PM with the Maintenance Supervisor, revealed he was unaware the items could not be permanently stored in the corridor of this area.</p> <p>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.</p>	K 072		
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