

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

PRINTED: 02/13/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186329	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/30/2014
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NAME OF PROVIDER OR SUPPLIER MORGANFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH CARRIER ST. MORGANFIELD, KY 42437
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<p>F 000</p> <p>F 281 SS=D</p>	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey Investigating #KY21203 was conducted on 01/28/14 through 01/30/14 to determine the facility's compliance with Federal requirements. #KY21203 was substantiated with a deficiency cited at a scope and severity of a "D".</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of a physician order, meal card and the facility's "Therapeutic Diet" policy, it was determined the facility failed to follow the physician's order for a "No Added Salt" (NAS) diet for one (1) of four (4) sampled residents (Resident #3). Resident #3 asked for salt during the noon meal and the Registered Nurse (RN) gave the resident the salt without providing education she was on a NAS diet and/or offering a salt substitute.</p> <p>The findings include: Review of the facility policy titled, "Therapeutic Diets", (no date), revealed mechanically altered diets, as well as diets modified for medical or nutritional needs, will be considered "therapeutic diets". A therapeutic diet must be prescribed by the resident's Attending Physician. The physician's diet order should match the terminology used by Food Services. The Food</p>	<p>F 000</p> <p>F 281</p>	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any 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 should in no way be construed or considered as an agreement with the allegations of noncompliance or</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Mary G. Wood* TITLE: *Administrator* (X6) DATE: *2/11/14*

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 281	<p>Continued From page 1</p> <p>Services Manager will establish and use a tray identification system to ensure that each resident receives his or her diet as ordered. Residents on therapeutic diets will not receive extra or reduced portions or modifications that are not part of the diet, unless approved by the Attending Physician in conjunction with the Clinical Dietitian.</p> <p>Record review revealed the facility admitted Resident #3 on 10/03/12 with diagnosis which included Congestive Heart Failure, Atrial Fibrillation and Hypertension. Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/14/13, revealed the facility assessed Resident #3 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of fourteen (14).</p> <p>Review of the January 2014 Physician's orders revealed the resident should receive a Consistent Carbohydrate (CCHO), No Added Salt (NAS), Mechanical Soft Diet.</p> <p>Observation of the lunch meal in the dining room, on 01/29/14 at 12:25 PM, revealed Resident # 3 received his/her meal tray. A review of the meal card revealed the resident's diet was a mechanical soft CCHO with NAS. Further observation revealed Resident #3 asked for salt and pepper, and Registered Nurse (RN) #1 crossed the room to obtain the shakers for the resident as requested. The shakers were given to the resident who used them on his/her food. The RN did not provide education to the resident related to the NAS diet or offer the resident a salt substitute.</p> <p>Interview with RN #1, on 01/29/14 at 12:30 PM, revealed she should have checked the resident's</p>	F 281	<p>admission by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p> <p>F 281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <ol style="list-style-type: none"> 1) On 2/17/14 the Dietary Services Manager reviewed the meal served to resident # 3 and noted that the physicians prescribed diet was offered, R#3 was educated by Dietary Manager and SSD on the NAS diet and must follow diet. MD notified on 1/29/14 and does not want R #3 to have a salt substitute. RN in dining room on 1/29 has been reeducated on giving resident diet ordered by physician and to educate resident on correct diet. 2) On 2/17/14 the Dietary Manager and Director of Nursing, RN observed all residents meal service and 		

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F 281	Continued From page 2 meal card prior to giving the resident the requested salt as the resident was on a NAS diet. Interview with the Dietary Manager, on 01/29/14 at 2:12 PM, revealed NAS means no added salt and the residents with this dietary restriction should not receive additional salt. Interview with the Registered Dietician, on 01/29/14 at 2:34 PM, revealed the diet menus are specific to each resident and their diet type and are to be followed by the dietary department as to those restrictions. Interview with the Administrator, on 1/30/14 at 11:51 AM, revealed when the meal trays are distributed the staff should check for correctness before delivery to the resident.	F 281	noted that the physicians prescribed diet was served. 3) All dietary staff and all nursing staff licensed and certified nursing assistants will be re-educated by the Dietary Service Manager, Director of Nursing or Assistant Director of Nursing by 2/19/14 related to validating the resident's diet by use of the tray card or physician order to assure that they are following the physician's orders for diet when offering substitutions or salt. This training will be completed by 3/7/14 with no staff working after 3/7/14 without having received this education. 4) The Dietary Manager will observe ten (10) resident meals per week for twelve (12) weeks to assure that all the physician orders for diet is followed. These observations will be reviewed with the Quality Assurance Committee monthly for at least (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 consist of at a minimum the Director of Nursing, the Assistant Director of Nursing, the Social Service Director, the Dietary Manager and the Administrator with the Medical Director attending at least quarterly.

5) Correction date is 3/8/14