

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

PRINTED: 06/28/2011  
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  06/16/2011
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  A standard health survey was conducted 06/14/11 through 06/16/11 and a Life Safety Code survey was conducted on 06/14/11. Deficiencies were cited with highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	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 (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 timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy Cleaning and Sanitizing, it was determined the facility failed to prepare and distribute food under sanitary conditions as evidenced by dust on the stove's hood vent cover.  The findings include:  Policy review of the Cleaning and Sanitizing procedure dated July 2010 revealed the entire Nutrition Services Team maintains clean and sanitary kitchen centers and equipment. Walls, floors, ceilings, equipment, and utensils are	F 371		F 371 FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

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

TITLE

(X6) DATE

*May G. Wood*

*Administrator*

*7/6/11*

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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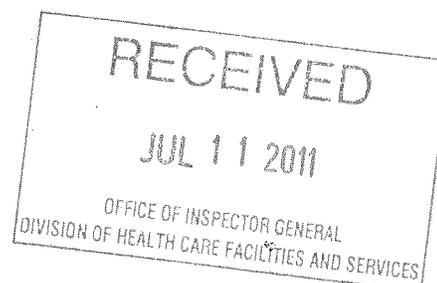
OFFICE OF INSPECTOR GENERAL  
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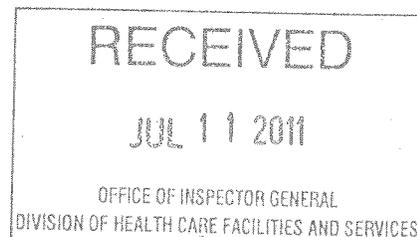
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F 371	Continued From page 1 clean, sanitized, and in good working order.  Review of the Dietary Services Cleaning Schedule, dated June 2011, revealed the stove vent cover was not listed as an area to be cleaned.  Observation during the kitchen tour, on 06/14/11 at 10:15am and on 06/16/11 at 9:30am, revealed the vent cover to the stove hood was covered with a gray dust build up. This vent cover was located directly over the burners to the stove.  Interview with Maintenance Manager (MM), on 06/16/11 at 9:30am, revealed the kitchen hood inspection and cleaning was outsourced and was last cleaned on 03/09/11. The MM stated the vent cover was to be cleaned by the kitchen staff.  Interview with the Dietary Manager (DM), on 06/16/11 at 9:40am, revealed she acknowledged the stove vent cover needed to be cleaned. The DM stated the dust from the vent cover could fall into resident's food while it was cooking on the stove and cause contamination. The DM reported the Maintenance Manager was responsible for cleaning the vent.	F 371	1. On 6/16/11 the stove vent cover was removed by maintenance manager and cleaned via the dishwasher by dietary aide. 2. On 6/16/11 all vents in the kitchen were inspected by the maintenance manager and cleaned if needed. 3. Facility will follow cleaning and sanitizing policy by adding kitchen stove's hood vent cover to the facility's kitchen cleaning schedule. Cleaning schedule will be weekly or as needed as a joint effort by dietary staff and maintenance manager. Dietary staff and maintenance manager were re-educated on 6/29/11 and the joint procedure of the cleaning procedure were discussed indicating that maintenance manager would check stove vent cover 5 days per week during rounds and if cleaning is needed, will remove and give to dietary aide to put through dishwasher to clean. 7/28/11	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient	F 514	4. Dietary manager or designee will check the kitchen cleaning schedule weekly to ensure that the kitchen stove's hood vent cover has been cleaned at least weekly or as needed per maintenance/dietary staff recommendations. Audits of kitchen stove's hood vent cleaning will be reviewed by QA committee monthly to ensure	



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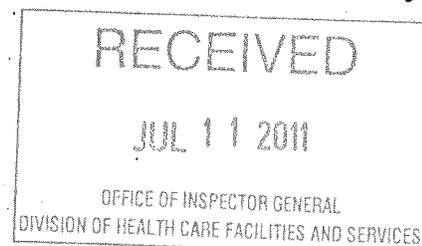
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F 514	Continued From page 2 information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy Verbal Physician Orders, it was determined the facility failed to maintain clinical records, as evidenced by verbal physician's orders that did not include dosages when medications were ordered for three (3) of the sixteen (16) residents sampled (Residents #2, 5 and 14).  The findings include:  Review of facility policy regarding verbal physician's orders revealed each medication order should include route, dosage, frequency, strength, reason for administration and stop date (for antibiotics).  1. Record review revealed the facility obtained a verbal physician's order, via the telephone for Resident #5, dated 06/16/11 to include "Increase K+ to three times daily". There was no evidence that a dosage had been included in the order.  Interview with the Assessment Coordinator, on 06/16/11 at 11:30am, revealed the nurse responsible for completing the verbal telephone order was not available, and revealed the nurse should have clarified the order with the physician	F 514	compliance and for further recommendations. 5. Correction date: 7/20/11  F 514 RESIDENT RECORDS-COMplete/ACCURATE/ACCESSIBLE  1 Resident #5's physician order for K was clarified with physician on 6/16/11 and order was wrote to include dosage. Resident #2 order for Ativan was clarified with physician on 6/18/11 and order was wrote to include dosage of medication Resident #14's order for Cipro was written for 10 days & with stop date on 3/31/11. Resident #14 had a dx: GERD on admission in History and Physical. Resident #14 was discharged on 6/4/11. 2. All current physician orders for in-house residents reviewed by DON, ADON on 6/24/11 to ensure all orders include route, dosage, frequency, strength, reason for administration, and antibiotics include stop dates. 3. All licensed nurses were re-educated by DON/ETD on 6/16-6/20/11 regarding requirement to ensure physician orders include route, dosage, frequency, strength, reason for administration and antibiotic orders contain stop dates. No nurse will work past 6/20/11 without receiving the education. 4. Director of Nursing or Assistant Director of Nursing will review all new physician orders daily Mon – Friday to ensure all orders include route, dosage, frequency, strength, reason for	



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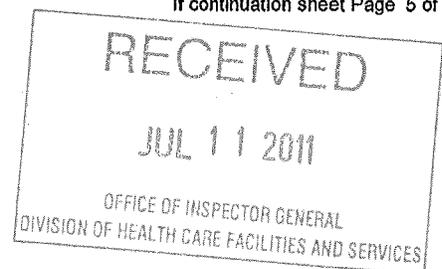
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F 514	Continued From page 3 and specified dosages.  2. Record review revealed the facility obtained a verbal physician's order, via the telephone for Resident #14, on 06/03/11 to include "Lorazepam 3xday, give 1 tab now". There was no evidence that a dosage or reason for administration had been included in the order.  3. Record review for Resident #14 revealed the facility obtained a verbal physician's order on 03/21/11 to include "Cipro 500mg 1 po BID for 10 days". There was no evidence of a stop date for that antibiotic order.  4. Record review for Resident #14 revealed the facility obtained a verbal physician's order via the telephone on 03/22/11 to include "Start Prilosec OTC po daily". There was no evidence that a dosage or reason for administration had been included in the order.  Interview with RN#1, on 06/16/11 at 9:05am, revealed she was able to list the required elements of a verbal physician order. RN #1 reviewed the orders written on Residents #2 and #14 and stated they were not written correctly.  Interview with Director of Nursing (DON), on 6/16/11 at 10:40am, revealed the nurses who had written the orders in question were unavailable. The DON was able to list the required elements of a verbal physician order correctly per facility policy. She stated the facility had not had issues with incorrectly written verbal physician orders in the past. She stated the orders had been written incorrectly and could lead to a resident receiving	F 514	administration and antibiotic orders contain stop dates. Results of audit will be reviewed by QA committee monthly to ensure sustained compliance and for any further recommendations.	7/6/11



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F 514	Continued From page 4 the incorrect dosage. The DON stated she reviews all new orders on a daily basis and she did not know why these orders were not identified to be corrected.	F 514			



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K 000	INITIAL COMMENTS	K 000	LIFE SAFETY CODE STANDARD	
K 029 SS=D	<p>A Life Safety Code Survey was initiated and concluded on 06/14/2011. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 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</p> <p>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, per NFPA Standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds and the census was fifty-eight (58) on the day of the survey.</p> <p>The findings include:</p>	K 029	<p>K 029</p> <ol style="list-style-type: none"> <li>On 6/14/11 a new closer for the door to the boiler room was ordered and installed on 6/24/11.</li> <li>On 6/24/11 all doors were again checked by maintenance to ensure compliance.</li> <li>On 6/30/11 Administrator in serviced maintenance manager to add to his rounds, door closer compliance.</li> <li>Maintenance manager will add inspection of door closure to his rounds to ensure that they are working properly and facility is in compliance.</li> <li>Correction date: 6/24/11</li> </ol>	6/24/11
		K 072	<p>K 072</p> <ol style="list-style-type: none"> <li>Wheelchairs located outside of the resident rooms on south side of Hall 1 will be stored elsewhere or moved every 30 minutes to ensure means of egress are</li> </ol>	

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

*May H Wood*

TITLE

*Administrator*

(X6) DATE

*7/6/11*

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If continuation sheet Page 1 of 4

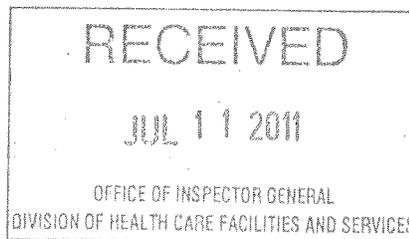
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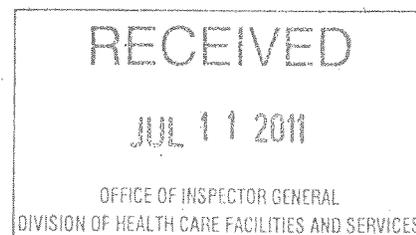
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K 029	<p>Continued From page 1</p> <p>Observation, on 06/14/2011 at 12:30 PM, with the Maintenance Supervisor revealed the closer on the door to the Boiler Room had been broken and would not self close.</p> <p>Interview, on 06/14/2011 at 12:30PM, with the Maintenance Supervisor revealed a confirmation that the closer was broken and needed replacement.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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<sup>2</sup> (9.3 m<sup>2</sup>) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft<sup>2</sup> (4.6 m<sup>2</sup>),</p>	K 029	<p>maintained free and clear of obstructions according to NFPA standards.</p> <ol style="list-style-type: none"> <li>2. Rounds were conducted by ADM on 7/1/11 to ensure all means of egress are maintained free of obstructions..</li> <li>3. Facility will assess resident's rooms that have available space for folded wheelchairs to be stored safely with remaining wheelchairs in hallway and moved every 30 minutes. Staff will be re-educated on 7/20 on the requirement to ensure all means of egress are maintained free of obstructions.</li> <li>4. Placement of wheelchairs will be monitored by Caring Partner on a daily basis to ensure compliance.</li> <li>5. Completion date: 7/20/11</li> </ol>	7/20/11



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K 029	Continued From page 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. NFPA 101 LIFE SAFETY CODE STANDARD	K 029		
K 072 SS=F	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 ensure means of egress were maintained free and clear of obstructions according to NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, approximately thirty (30) residents, staff and visitors. The facility has the capacity for sixty (60) beds and the census was fifty-eight (58) on the day of the survey.  The findings include:  Observation, on 06/14/2011 between 10:00 AM	K 072		



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K 072	<p>Continued From page 3 and 12:30 PM, with the Maintenance Supervisor revealed several wheelchairs located outside of the resident rooms on the South side of Hall 1 to be stationary for a period of more than thirty (30) minures.</p> <p>Interview, on 06/14/2011 during the exiting conference at 2:00 PM, with the Administrator and the Maintenance Supervisor confirmed the wheelchairs located on one side of the corridor and indicated the facility lacked in storage space. The Administrator acknowledged the need for additional Staff training to maintain the corridors free of obstructions.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>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			

