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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185006		12/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN CARE & REHABILITATION CENTER	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 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.	
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 Cloud
TITLE: IVHA
(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	Continued From page 1 by: 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. Findings include: 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." 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. 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. A review of the significant change Minimum Data Set (MDS) assessment, dated 11/18/11, revealed	F 279	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 a10% monthly audit of residents to ensure care plans are updated and revised. 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.	

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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	Continued From page 3 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. Findings include: 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." 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. 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	F 281	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	Continued From page 4 daily (BID) for Alzheimer's" at 8:00 AM and 4:00 PM. 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. 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. 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. 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." A record review revealed Resident #20 was admitted to the facility on 03/04/11 with diagnoses	F 281	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.	

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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	Continued From page 6 function as possible. 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. Findings include: 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." 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. 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.	F 315	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. 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.	

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F 315	Continued From page 7 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. 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. 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. 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.	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.	