

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

PRINTED: 06/18/2010  
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  06/10/2010
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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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F 000	INITIAL COMMENTS  An annual survey was conducted 06/08/10 through 06/10/10 to determine the facility's compliance with Federal Regulatory Requirements. Deficiencies were cited with the highest scope and severity being a "D".	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 and plan of correction. In addition, preparation 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 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431	F 431 LABELING OF DRUGS AND BIOLOGICALS  1. On 6/10/10, expired tube feeding and Isopropyl Alcohol were removed from storage and discarded. 2. On 6/10/10, the medical storage rooms and medication carts were inspected to ensure no other expired drugs or biologicals were present.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Janet A. Parley RN</i>	TITLE <i>Director of Nursing</i>	(X6) DATE 6/28/10
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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 431	<p>Continued From page 1 be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, included the appropriate accessory and cautionary instructions and the expiration date, when applicable. The medication room contained (12) bottles of Glucerna 1.0 with an expiration date of 05/01/10, (25) bottles Glucerna 1.0 with an expiration date of 06/01/10, and (15) cans of Osmolite 1.5 with an expiration date of 04/01/10. Findings include:</p> <p>Observation on 06/10/10 at 10:20 AM, in the medication room on Hall Two, reveale (12) 1000 milliliter bottles of Glucerna 1.0 with an expiration date of 05/1/10; (25) 1000 milliliter bottles of Glucerna 1.0, with an expiration date of 06/01/10; (15) 8 ounce cans of Osmolite 1.5, with an expiration date of 04/01/10 and three bottles of 70% Isopropyl Alcohol, with an expiration date of 04/10, were available for use.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 06/10/10 at 10:35 AM, revealed the person assigned to medical records was designated responsible for checking the medication rooms for expired supplies and replacing the supplies. She stated, "the feedings should be discarded; because they were expired".</p> <p>An interview with the Central Supply Clerk, on</p>	F 431	<p>3. On 6/10/10, Central supply clerk was reeducated on requirement to inspect medical storage rooms monthly and remove any expired drugs or biologicals.</p> <p>4. DON or ADON will inspect medical storage rooms and medication carts weekly for 4 weeks and then monthly for 3 months to ensure no expired drugs or biologicals are present. Results of audits will be brought to monthly QPI meeting for review and further recommendations.</p>	6/11/10	

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F 431	<p>Continued From page 2</p> <p>06/10/10 at 1:00 PM, revealed she was responsible for maintaining the supply room. She stated there was no specific schedule to ensure the supply room was checked. She stated she checked it every third day and daily at times. She did not know of a system to check and discard supplies in the medication room. Additionally, the Central Supply Clerk stated she did not know some of the items, such as Isopropyl Alcohol stored in the medication room, had an expiration date. She stated the company which supplied the feedings collected items that were mistakenly sent to the facility; however, there was no agreement with the company regarding handling outdated enteral feedings.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 06/10/10 at 1:15 PM, revealed she was uncertain regarding how often the central supply inventory was checked and if the facility had a policy/procedure developed. She stated, "That stuff that's expired should have been discarded".</p> <p>An interview with the DON, on 06/10/10 at 2:35 PM, revealed the Central Supply Clerk checked the medication room, the first week of every month. She stated there was no policy/procedure developed and implemented to ensure maintenance of supplies in the medication room. The DON stated, "Anything expired should be disposed of."</p> <p>An interview, on 06/10/10 at 2:40 PM, with the representative from the company which supplied the enteral feedings revealed the company had informed the facility to discard the expired feedings stating, "I explained we can't resale expired feedings and we can't credit their account</p>	F 431			

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F 431	Continued From page 3 for expired products".	F 431			

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K 000 INITIAL COMMENTS

A Life Safety Code survey was initiated and conducted on 06/08/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency identified at an F.

K 062 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=F

Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6. 4.6.12, NFPA 13, NFPA 25, 9.7.5

This STANDARD is not met as evidenced by:  
Based on observation and staff interview conducted on 06/08/10, it was determined the facility failed to ensure sprinkler heads were free of corrosion as required by NFPA 25 1999 Edition.

The findings to include:

A tour of the facility conducted 06/08/10 at 10:30 AM, revealed sprinkler heads throughout the facility had a build-up of corrosion.

An interview with the Administrator and Maintenance Director on 06/08/10 at 10:35 AM, revealed the sprinkler heads were at least twenty years old.

Reference to:  
NFPA 25 1999 Edition

K 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 and plan of correction. In addition, preparation 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.

K 062

K062 NPA 101 LIFE SAFETY CODE STANDARD

1. Sprinkler heads identified with corrosion are scheduled to be replaced by 7/25/10.
2. Armor Fire Protection and Maintenance Director conducted audit of sprinkler heads on 6/10/10 to identify any other sprinkler heads needing replacement. All identified

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

TITLE

(X6) DATE

*Just Penley RW* Director of Nursing 6/28/10

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K 062	Continued From page 1 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	with corrosion are scheduled to be replaced by 7/25/10. 3. On 6/10/10, Maintenance Director was re-educated on requirement that automatic sprinkler systems are continuously maintained in reliable operating condition and inspected and tested periodically. 4. Maintenance Director will conduct monthly audits of sprinkler heads to ensure they are in reliable operating condition. Results of audits will be forwarded to QA committee for review and further recommendations.	7/25/10
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4  This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 06/08/10, it was determined the facility failed to ensure decorations used in the facility were flame-retardant as required by NFPA 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.  The findings include:  Observations during the Life Safety Code tour, conducted on 06/08/10, at 1:15 PM, revealed doors throughout the facility were decorated with wreaths.  An interview conducted with the Maintenance Director, on 06/08/10 at 1:30 PM, revealed the wreaths had been put on the doors by family members, the facility did not have any documentation that would indicate the flame rating of	K 073	K073 NPA 101 LIFE SAFETY CODE STANDARD  1. Identified decorations were removed from doors and rooms on 6/8/10 and treated with flame-retardant on 6/15/10. 2. On 6/8/10, Maintenance Director conducted round to identify any other decorations in center that were not flame-retardant. All identified items were removed from rooms on 6/8/10 and treated with flame-retardant on 6/15/10. 3. Maintenance Director was re-educated on 6/10/10 regarding requirement that decorations used in center are flame-retardant. Family members of current residents were notified of requirement. Families of new admissions will be notified of requirement upon admission. 4. Maintenance Director will conduct rounds monthly to ensure no combustible decorations are used in center unless they are flame retardant. Results of rounds will be forwarded to	6/15/10

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			QA committee monthly for review and further recommendations.		