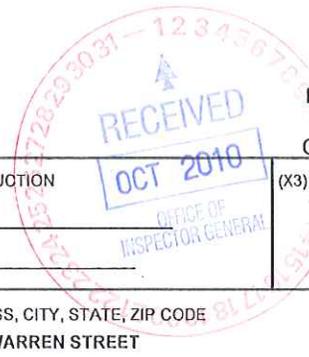


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/24/2010
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2010
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NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 206 SOUTH WARREN STREET MORGANTOWN, KY 42261
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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
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F 000	INITIAL COMMENTS An annual survey and abbreviated surveys (KY #15305 and KY #15111) were conducted 09/08/10 through 09/10/10 to determine the facility's compliance with Federal regulations. The facility failed to meet minimum requirements for recertification with the highest S/S of "D". KY # 15305 and KY # 15111 were found to be unsubstantiated with no deficiencies cited.	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 waiver 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 222 SS=D	483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to ensure one resident (#25), not in the selected sample, was afforded the right to be free of any chemical restraint not required to treat the resident's medical condition. Findings include: Resident #25 received Ativan 1mg IM (Intramuscular), PRN (as needed) every eight hours for agitation. The facility failed to provide evidence of an assessment of the resident and identity of a medical symptom that would require the injectable form of Ativan, show that other lesser restrictive interventions had been attempted and found ineffective and consult with the resident's physician, prior to the administration of the injectable drug. Findings include:	F 222	1. Resident #25 Ativan 1mg IM was discontinued on 9/9/10. 2. A 100% audit was completed to identify any residents receiving PRN IM psychotropic medications. None were identified.	10/4/10

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

TITLE

(X6) DATE

J. Mary Clark

NHA

9/30/10

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 222	<p>Continued From page 1</p> <p>A review of the facility's policy, entitled "Psychotropic Drug Use," dated July 2002, revealed a request for the use of a psychotropic drug from the physician would only occur with the recommendation of the interdisciplinary team, to include routine and prn medication. A nurse could request a "one-time" medication order in the case of an emergency, for example explosive behaviors or potential for significant harm to others.</p> <p>A record review revealed Resident #25 was admitted to the facility, on 07/25/07, with diagnoses which included Dementia with Psychosis and Disturbance of behaviors, Anxiety, and Depression.</p> <p>A review of the significant change Minimum Data Set (MDS) assessment, dated 07/12/10, revealed the facility identified Resident #25 as moderately cognitively impaired with socially inappropriate/disruptive behavior.</p> <p>A review of the Comprehensive Care Plan, dated 03/06/10, for the problem of behavior disturbance revealed the resident was identified as exhibiting behaviors which included verbal abuse directed at staff, socially inappropriate behaviors, such as yelling, episodes of repetitive and restless behavior, verbalizing statements such as "I'm sick enough to die", physical abuse directed at staff and threatening staff and hitting staff, at risk for wandering and elopement, refusing meals, showers and medication.</p> <p>A review of the physician orders, dated 08/19/10, revealed a current order for Ativan which could be administered by injection every eight hours as needed, for "anxiety".</p>	F 222	<p>3. An in-service was provided on 9/21/10 to nursing staff by the Staff Development Coordinator regarding behavioral interventions prior to medication administration. All physician orders will be audited by the DON or designee during clinical meeting to ensure that no PRN IM psychotropic medications have been ordered. In the event that one has been ordered the physician will be contacted to discontinue the medication.</p> <p>4. The order audit completed in clinical meeting will be reviewed by the Quality Assurance Committee monthly for 3 months for recommendations and further follow up as indicated.</p>	

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F 222	<p>Continued From page 2</p> <p>A review of the Medication Administration Records (MAR), for the period of November 2009 through September 2010, revealed Ativan 1 mg was administered by injection to Resident #25 on 16 different occasions, for "agitation".</p> <p>A review of Nurses Notes for the corresponding administration dates (10/31/09, 11/12/09, 11/13/09, 11/20/09, 02/20/10, 03/07/10, 03/21/10, 03/24/10, 04/16/10, 04/23/10, 06/17/10, 07/12/10, 07/14/10, 08/09/10 and 09/01/10), revealed no evidence of an assessment/description of the resident's behavior, and no alternative interventions attempted with the resident's response, prior to administration of the injectable Ativan. There was no evidence provided through record review or staff interview of a consultation with the resident's physician prior to the administration of the injectable psychoactive drug.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 09/10/10 at 4:00 PM, revealed Resident #25 was anxious and became agitated easily. He/she struck out and was verbally abusive with staff and had attempted to break a window. The most effective intervention was to call his/her daughter and the daughter would come and sit with the resident until the resident was calm. Other interventions which proved effective included to provide the resident with a snack and then assist him/her to the lobby to watch TV.</p> <p>An interview with LPN #2, on 09/10/10 at 4:10 PM, revealed Resident #25 hit others when agitated. An effective intervention to reduce the agitation and calm the resident included rubbing the resident's abdomen.</p>	F 222			

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F 222	Continued From page 3 An interview with the Director of Nursing, on 09/10/10 at 2:45 PM, revealed she was aware Resident #25 had a routine PRN order for injectable Ativan, which was used to control behaviors/agitation exhibited by the resident.	F 222		
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 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed ensure catheter care was provided appropriately to prevent urinary tract infections for one resident (#2), in the selected sample of 24. Findings include: A record review revealed Resident #2 was admitted on 08/07/08 with diagnoses to include Huntington's Chorea, Depressive Disorder, Urosepsis, Metabolic Acidosis, Hyperglycemia, and Aphasia. A review of the annual Minimum Data Set (MDS) assessment, dated 06/16/10, revealed the facility identified Resident #2 as severely cognitively impaired, incontinent of bowel, having an	F 315	<ol style="list-style-type: none"> 1. Resident #2 was observed for seven days from 9/9/10 to ensure there were no signs or symptoms of a urinary tract infection. 2. All residents with an indwelling foley catheter were observed for seven days from 9/9/10 to ensure there were no signs or symptoms of urinary tract infections. 3. An in-service was provided by the Staff Development Coordinator on 9/10/10 to nursing staff regarding providing proper catheter care. An audit of nursing staff providing Foley catheter care will be performed by the Staff Development Coordinator weekly for 4 weeks to ensure nursing staff is providing proper catheter care. 	10/4/10

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F 315	<p>Continued From page 4</p> <p>indwelling urinary catheter and requiring total assistance with activities of daily living. A review of the care plan, dated 07/21/10, for "Urinary Catheter", revealed an indwelling catheter was utilized due to urinary retention.</p> <p>An observation, on 09/09/10 at 9:20 AM, revealed Certified Nurse Assistant (CNA) #1 did not provide appropriate catheter care for Resident #2. CNA #1 cleansed the catheter tubing with the same washcloth she previously used to provide perineal cleansing. After the perineal and catheter care was provided, CNA #1 was observed to reposition the resident and provide incontinent care. After the incontinent care was provided, CNA #1 applied Calazime cream (moisture barrier) to the resident's buttocks with her hand, repositioned the resident and applied the cream to the resident's perineal area with the same hand.</p> <p>An interview with CNA #1, on 09/09/10 at 10:30 AM, revealed she was aware a clean washcloth should have been obtained and used between skin contact and the catheter tube care. She understood the risk for contamination when applying cream from the rectal area towards the perineal area.</p> <p>An interview with the Director of Nursing, on 09/09/10 at 1:25 PM, revealed staff were expected to obtain and use a clean washcloth after provision of skin care and before provision of catheter care. She stated creams should be applied from front to back to prevent contamination. She stated, "I expect staff to follow the policies for providing care."</p> <p>A review of the policy/procedure for "Catheter</p>	F 315	<p>4. The catheter audit will be reviewed by the Quality Assurance Committee monthly for 3 months for recommendations and further follow up as indicated.</p>		

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F 315	Continued From page 5 Care-Indwelling", (undated) revealed the resident should be placed onto a bedpan and the catheter exposed. A soapy washcloth should be used to carefully wash around the urethral meatus (opening to the bladder) and the adjacent catheter and rinse thoroughly. Warm water should be poured over the entire perineum, vulva, urethra, and 2-3 inches of the catheter, then pat dried with a clean washcloth.	F 315		
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure staff used proper handwashing after each direct resident contact for one resident (#2), in the selected sample of 24. Findings include: A record review revealed Resident #2 was admitted, on 08/07/08, with diagnoses which included Huntington's Chorea, Depressive Disorder, Urosepsis, Metabolic Acidosis, Hyperglycemia, and Aphasia. A review of the annual Minimum Data Set (MDS), dated 06/16/10, revealed the facility identified Resident #2 as severely cognitively impaired and requiring total assistance with activities of daily living.	F 444	1. Surfaces in resident #2's room were cleaned by housekeeping staff on 09/10/10. 2. An in-service was provided to nursing staff on 09/28/10 regarding hand-washing and infection control. 3. An audit will be performed during provision of catheter care by the Staff Development Coordinator weekly for 4 weeks to ensure nursing staff is displaying proper hand-washing techniques during resident care.	10/4/10

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F 444	<p>Continued From page 6</p> <p>An observation, on 09/09/10 at 9:20 AM, revealed Certified Nurse Aide (CNA) #1 used hand sanitizer prior to entering Resident #2's room. CNA #1 did not wash her hands prior to donning her gloves in preparation of provision of catheter/incontinent care. After providing catheter/incontinent care, CNA #1 did not remove her gloves or wash her hands. While wearing the gloves used for the catheter/incontinent care, CNA #1 placed the resident's personal supplies in a drawer, pulled the privacy curtain back, washed out the resident's wash basin and placed the basin in the resident's closet prior to removing the contaminated gloves and washing her hands.</p> <p>An observation, on 09/09/10 at 9:20 AM, revealed CNA #2 used hand sanitizer prior to entering Resident #2's room. CNA #2 did not wash her hands prior to donning gloves and assisting with catheter/incontinent care. During provision of care, CNA #2 obtained an incontinent pad from the closet without removing her contaminated gloves. After provision of the care, CNA #2 exited the resident's room, carrying soiled linen and wearing the same pair of gloves. She re-entered the room, removed the soiled gloves and washed her hands.</p> <p>An interview with CNA #1, on 09/09/10 at 10:30 AM, revealed she was aware she should have removed the soiled gloves and washed her hands prior to touching objects in the resident's room. She stated, "I have a thing about contaminating myself and I don't like to take off my gloves until I am completely finished."</p> <p>An interview with CNA #2, on 09/09/10 at 10:40 AM, revealed she realized she should have removed her gloves prior to obtaining the</p>	F 444	4. The hand-washing audit will be reviewed by the Quality Assurance Committee monthly for 3 months for recommendations and further follow up as indicated.		

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F 444	Continued From page 7 incontinent pad from the resident's closet. She further stated she was aware she should removed her gloves and washed her hands after provision of resident care. An interview with the Director of Nursing, on 09/09/10 at 1:25 PM, revealed staff should wash their hands before and after resident care, as well as before exiting the resident's room. A review of the facility's policy/procedure entitled "Hand Washing", dated July 2002, revealed staff would wash their hands before and after caring for each resident and/or their units, including anything the resident had touched.	F 444			

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K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and conducted on 09/09/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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