

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

PRINTED: 08/07/2014
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 07/25/2014
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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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F 000	INITIAL COMMENTS	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 allegations 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 then (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	
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's Bill of Resident Rights, it was determined the facility failed to promote care for residents in a manner that maintained or enhanced each resident's dignity and respect related to the observation of facility staff entering four (4) resident rooms without knocking on the door.</p> <p>Findings include:</p> <p>Review of the facility's Bill of Resident Rights, dated 07/01/09, revealed residents have the right to receive care from the center in a manner that promotes, maintains, or enhances their dignity and respect in full recognition of their individuality.</p> <p>Observation of a medication pass, on 07/24/14 at 7:55 AM, 8:00 AM, 8:10 AM, and 8:25 AM, revealed Registered Nurse (RN) #2 entered room #24, #25, #30, and #26, respectively, without</p>	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Mary L. Wood ADMINISTRATOR TITLE
8/22/14 (X6) DATE

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 241	Continued From page 1 knocking on the door. Observation, on 07/24/14 at 2:15 PM, revealed RN #2 entered room #30 to observe a Peripherally Inserted Central Catheter (PICC) dressing, without knocking on the door. Interview with RN #2, on 07/24/14 at 2:20 PM, revealed she was suppose to knock on the door and announce herself before entering a resident's room. Interview with the Director of Nursing (DON), on 07/25/14 at 10:30 AM, revealed she expected staff to knock on the door and announce themselves before entering a resident's room.	F 241	admission by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements. F 241 DIGNITY AND RESPECT OF INDIVIDUALITY 1) On August 13, 2014 re-education was provided to Registered Nurse (RN#2) to the facility's Bill of Rights to receive care in a manner that promotes, maintains, or enhances their dignity and respect by knocking on the resident's door and announcing herself before entering the resident's room. 2) On 8/13/14, the Director of Nursing observed that staff were knocking on the door and announcing them self. 3) All staff will be re-educated by the Director of Education and Training, the Director of Nursing or Assistant Director of Nursing by 9/6/14 on facility's Bill of Rights related to dignity and respect before entering resident's rooms. No staff will work past 9/6/14		
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	F 279			

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F 279	<p>Continued From page 2 under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to develop a comprehensive care plan for each resident that included appropriate interventions for one resident (A), not in the selected sample, related to the care of a Peripherally inserted Central Catheter (PICC).</p> <p>Findings include:</p> <p>Review of the facility's Resident Comprehensive Care Plan policy/procedure, dated 09/08, revealed the resident's comprehensive care plan should be viewed as an Interdisciplinary approach to managing the acute and chronic needs of the resident living in the facility. The comprehensive care plan was comprised of the following documents and disciplines, including the documentation of treatments on the resident's Treatment Administration Record.</p> <p>Review of Resident A's Infection Comprehensive Care Plan, dated 07/07/14, revealed interventions to flush the PICC as ordered and observe the PICC for signs and symptoms of infection. The care plan did not address how often to change the dressing.</p> <p>Review of the Vascular Access Insertion Documentation, dated 07/18/14, revealed a PICC was placed with the site covered with gauze and Tegaderm (transparent dressing).</p> <p>Interview with the Minimum Data Set (MDS)</p>	F 279	<p>without having had this re-education.</p> <p>4) Observations will be performed by the Director of Nursing, Director of Education and Training or the Assistant Director of Nursing five (5) times per week for four (4) weeks then weekly for eight (8) weeks. Observations will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the facility will convene a Quality Assurance Committee meeting to review for further recommendations. The Quality Assurance Committee meeting consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Social Services Director, Dietary Service Manager and Maintenance Director with the Medical Director attending at least quarterly.</p> <p>F 279 DEVELOP COMPREHENSIVE CARE PLANS</p> <p>1) On July 25, 2014, Resident A's Infection</p>	9/7/14	

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F 279	Continued From page 3 Coordinator, on 07/25/14 at 9:00 AM, revealed she implemented the infection care plan for Resident A, with interventions specific to the PICC. She revealed dressing changes were a part of the resident's routine care and should have been implemented on the care plan.	F 279	Comprehensive Care Plan was updated by MDS Nurse to include how often to change the PICC dressings. 2) All current residents' care plans will be reviewed by the Director of Nursing, MDS Nurse, Social Services Director, Activity Director and Dietary Services Manager by 9/6/14 to assure the care plans have been developed to meet the needs of the resident. Any needed care plans will be developed at that time. 3) All Interdisciplinary staff to include the Assistant Director of Nursing, MDS Nurse, Social Services Director, Activity Director and Dietary Services manager will be re-educated by the Director of Nursing relating to the development of comprehensive care plan to meet the needs of the resident by 9/6/14. 4) The Director of Nursing or the Assistant Director of Nursing will audit five (5) resident's comprehensive		
F 281 SS=E	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, and review of the facility's policy/procedure, it was determined the facility failed to ensure services provided met professional standards of quality for one resident (#1), in the selected sample of fourteen (14) residents, and three residents (C, D, E) not in the selected sample. Findings include: Review of the facility's Medication Administration policy/procedure, undated, revealed the licensed nurse would check the following to administer medications: right medication, right dose, right dosage form, right route, right resident, and right time. Document the administration of medication on the Medication Administration Record (MAR) as soon as medications were given.	F 281			

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F 281	Continued From page 4 Observation of a medication cart, on 07/23/14 at 9:50 AM, revealed the following narcotic medications were in the locked drawer, prepared in medication cups with a resident name on the cup: 1. Ativan (anti-anxiety) 0.5 milligrams (mg) one-half (1/2) tablet, pre-signed out for Resident #1 on the narcotic record for 07/23/14 at 2:00 PM 2. Norco (pain) 5-325 mg tablet, not signed out for Resident C on the narcotic record, as it was an as needed medication 3. Norco 10-325 mg tablet, pre-signed out for Resident D on the narcotic record for 07/23/14 at 2:00 PM 4. Ativan 0.5 mg tablet, pre-signed out for Resident E on the narcotic record for 07/23/14 at 2:00 PM Interview with Registered Nurse (RN) #1, on 07/23/14 at 9:55 AM, revealed she should not have set up narcotic medication in the cart; however, she would re-check the medications before actually administering to a resident. She revealed narcotics should be signed out when administering the medication. Interview with the Director of Nursing (DON), on 07/25/14 at 10:30 AM, revealed staff were expected to obtain medication and sign out narcotics upon administration of the medication. She revealed there was a potential for giving the medication at the wrong time or to the wrong resident when preparing the medications in advance. She revealed the facility's policy was the Standard of Practice for staff.	F 281	care plans per week for twelve (12) weeks to assure that the care plans have been developed to meet the needs of the resident. These audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the facility will convene a Quality Assurance Committee meeting to review for further recommendations. The Quality Assurance Committee will consist of a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Social Service Director, Dietary Service Manager and Maintenance Director with the Medical Director attending at least quarterly.		
F 328	483.25(k) TREATMENT/CARE FOR SPECIAL	F 328	F 281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	9/7/14	

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F 328 SS=D	<p>Continued From page 5 NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>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 residents received proper treatment and care for a Peripherally Inserted Central Catheter (PICC) for one resident (A), not in the selected sample.</p> <p>Findings include:</p> <p>Review of the Infusion Maintenance Table, revised March 2010, revealed site maintenance of a PICC included transparent dressing changes 24 hours post insertion or on admission, then every week and as needed.</p> <p>Observation of Resident A, on 07/24/14 at 8:10 AM and 2:15 PM, revealed the guaze dressing covering the PICC site was fully saturated with reddish/brown blood, covered with a transparent dressing, dated 07/18/14.</p> <p>Record review revealed Resident A was admitted</p>	F 328	<ol style="list-style-type: none"> 1) Registered Nurse (RN#1) was re-educated on 7/23/14 to the professional standards of quality related to the facility's Medication Administration policy/procedure to check the following to administer medications: right medication, right dose, right dosage form, right route, right resident and right time. Document the administration of medication on the Medication Administration Record (MAR) as soon as medications were given. 2) On 8/19/14 the Director of Nursing observed Medication Administration and noted that medications including narcotics were pulled and then signed out and that staff were following the six rights of medication administration with no concerns identified. 3) All licensed staff will be re-educated to facility's policy/procedure for 		

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F 328	Continued From page 6 to the facility on 07/01/12. Review of the Infection care plan, initiated 07/07/14, revealed the facility identified a redness and drainage to the resident's wound with intravenous antibiotic therapy. Review of the Vascular Access Insertion Documentation, dated 07/18/14, revealed the Vascular Access Nurse placed the PICC and covered with guaze and a transparent dressing. Review of the Physician's Order and Treatment Administration Record (TAR), dated 07/24/14, revealed to change the PICC dressing weekly. Interview with Registered Nurse (RN) #2, on 07/24/14 at 2:20 PM, revealed she was unsure of the facility's policy; however, it was common practice to change the PICC dressing weekly. She revealed pharmacy would send the supplies, which included a transparent dressing with no guaze. Interview by phone with the Vascular Access Nurse, on 07/25/14 at 8:20 AM, revealed she initially placed a guaze wick with a transparent dressing over the site, after insertion of a PICC. She revealed the dressing should be changed the next day to observe the site. She recommended a dressing change within 24 hours, then weekly thereafter. She revealed the main concern was to keep the site sealed. Leaving a saturated dressing can allow air underneath, leading to a potential for infection. Interview with the Director of Nursing (DON), on 07/25/14 at 10:30 AM, revealed she expected staff to follow the policy related to routine care of a PICC. She would have expected staff to remove the guaze dressing and assess the PICC.	F 328	medication administration to provide and meet professional standards of practice for quality to include removing narcotics when administered and signing out after administration by the Education and Training Director, Director of Nursing or the Assistant Director of Nursing by 9/6/14. No licensed staff will work past this date without having received this education. 4) Director of Nursing, Assistant Director of Nursing, Unit Manager or MDS Nurse will conduct medication administration will conduct medication administration observation/audits three (3) times per week for twelve (12) weeks to ensure Medication Administration policy/procedures are being provided and meet professional standards. These observations/audits will be reviewed with the		
F 332	483.25(m)(1) FREE OF MEDICATION ERROR	F 332			

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F 332 SS=D	<p>Continued From page 7 RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedure, it was determined the facility failed to ensure it was free of medication error rates of five (5) percent (%) or more involving one (1) of fourteen (14) sampled residents (Resident B). Observation during medication pass revealed twenty-five (25) opportunities with two (2) errors, which resulted in an eight (8)% medication error rate. The facility failed to ensure Resident B was given all morning medications as prescribed by the physician. The medications omitted were Aspirin (analgesic) 81 milligrams (mg) each day and Isosorbide (medication to treat chest pain) 60 mg each day.</p> <p>Findings include:</p> <p>Review of the facility's policy and procedure titled "Medication Administration" (no date), revealed "The licensed nurse and/or medication assistant will check the following to administer medication:</p> <ul style="list-style-type: none"> a. Right medication b. Right dose c. Right dosage form d. Right route e. Right resident f. Right time <p>Read the Medication Administration Record (MAR) for the ordered medication, dose, dosage form, route, and time."</p>	F 332	<p>Quality Assurance Committee monthly x three (3) months. If at any time 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, and the Administrator with the Medical Director attending at least quarterly.</p> <p>F 328 TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>1) Resident's PICC dressing was changed on 7/25/14 as documented on the Treatment Administration Record per MD order.</p> <p>2) An audit of all current resident's was conducted by the Director of Nursing on 7/29/14 to identify any resident with an</p>	9/7/14	

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F 332	<p>Continued From page 8</p> <p>Record review revealed the facility admitted Resident B on 03/28/14 with diagnoses which included Dementia without Behavioral Disturbance, Congestive Heart Failure, Esophageal Reflux, Hyperlipidemia, Anemia, Hypertension, Anxiety, Vertigo, and Atrial Fibrillation.</p> <p>Observation of a medication pass, on 07/23/14 at 8:30 AM, revealed the Minimum Data Set (MDS) Coordinator was administering medications to Resident B when she failed to administer two (2) medications, Aspirin (analgesic) 81 mg and Isosorbide (medication to treat chest pain) 50 mg, both to be given each day during the 8:00 AM medication pass.</p> <p>Review of the MAR, dated July 2014, revealed Resident B was ordered Aspirin (Analgesic) 81 mg each day and Isosorbide (medication to treat chest pain) 60 mg each day with a scheduled time of 8:00 AM.</p> <p>Interview with the MDS Coordinator, on 07/23/14 at 10:20 AM, revealed she missed giving the two (2) medications to Resident B because she was looking for a powder (Anoxa) (anti-anxiety medication) which was listed on the MAR, but was not on the medication cart. She administered the missed medications at 10:20 AM, which was one (1) hour and twenty (20) minutes past the scheduled medication pass time.</p> <p>Interview with the Registered Nurse (RN) Unit Manager (UM), on 07/25/14 at 9:45 AM, revealed she trained staff during orientation related to medication administration and a medication administration video was used with a quiz</p>	F 332	<p>Intravenous catheter to assure that dressing were changed per the IV policy. No concerns were identified.</p> <p>3) All licensed staff will be re-educated on policy/procedure related to PICC line dressing changes to include dressing changes 24 hours post insertion or on admission, then every week and as needed by the Education and Training Director, the Director of Nursing or the Assistant Director of Nursing by 9/6/14. No licensed staff will work after this date without having received this re-education.</p> <p>4) The Director of Nursing or the Assistant Director of Nursing will audit all residents with an Intravenous Catheter weekly for twelve weeks (12) to assure that dressings are changed per IV manual/policy. These observations/audits will be reviewed with Quality Assurance Committee monthly x three (3) months. If at any time concerns are identified, the facility will convene a Quality Assurance Committee meeting to review for further recommendations as needed. The</p>		

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F 332	Continued From page 9 afterward. She stated when a licensed nurse administered medications, the medication policy was to be followed. Interview with the Director of Nursing (DON), on 07/25/14 at 10:30 AM, revealed she expected staff to follow the six (6) rights of medication administration per the facility policy when administering medications.	F 332	Quality Assurance Committee will consist of a minimum the Director of Nursing, the Assistant Director of Nursing, the Social Services Director, and the Administrator with the Medical Director attending at least quarterly. F 332 FREE OF MEDICATION ERROR RATES OF 5% OR MORE 1) On 8/13/14, the MDS Nurse was re-educated by the Director of Nursing on Medication Administration including the six rights of administration. On 8/18/14 the Director of Nursing observed Medication Administration and noted that medications were administered per physician's order and the six rights of medication administration were followed. 2) On 8/20/14 the Director of Nursing observed Medication Administration and noted that medications were administered per	9/7/14	

physician's orders and the six rights of medication administration were followed

- 3) All licensed staff will be re-educated on the facility policy/procedure relating to Medication Administration regarding the 6 rights using the Medication Administration Record. If at any time a medication is passed the scheduled time, the nurse will notify the MD for any further orders relating to the medication. This education will be provided by the Director of Nursing or the Assistant Director of Nursing.
- 4) The Director of Nursing, Assistant Director of Nursing, Unit Manager or MDS Nurse will conduct medication administration observations/audits three (3) times per week for twelve (12) weeks and then monthly x three (3) months to ensure Medication Administration policy/procedures are being

9/17/14

provided and meet professional standards. These observations will be reviewed by the Quality Assurance Committee for three (3) months. If at any time 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 services Director, and the Administrator with the Medical Director attending at least quarterly.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185329	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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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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(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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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1965.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1966, and upgraded in 1992 with 19 smoke detectors and 114 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1966 and upgraded in 1998.</p> <p>GENERATOR: (2) Type II generators installed in 2009. Fuel source is Diesel.</p> <p>A standard Life Safety Code Survey was conducted on 07/24/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty (60) beds with a census of fifty-five (55) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<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 allegations 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 then (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</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Mary G. Wood* TITLE *Administrator* (X6) DATE *8/22/14*

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 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	
K 000	Continued From page 1 Fire).	K 000	should in no way be construed or considered as an agreement with the allegations of noncompliance or admission by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements. K 147 NFPA LIFE SAFETY CODE STANDARD 1) The two (2) identified unlocked electrical panels located in Hall # 1on 7/24/14 were immediately locked by the Maintenance Supervisor. 2) On 7/25/14 the Maintenance Supervisor audited the entire facility to ensure that all electrical panels were locked with no concerns found. 3) The Maintenance Supervisor was re-educated by the Administrator on the checking electrical panels to ensure that all are locked at all times on 8/20/14		
K 147 SS=D	Deficiencies were cited with the highest deficiency identified at "D" level. NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of four (4) smoke compartments, thirty (30) residents, staff and visitors. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was fifty-five (55). The findings include: Observation, on 07/24/14 at 12:20 PM with the Maintenance Supervisor, revealed two (2) unlocked electrical panels located in hall# 1. Interview, on 07/24/14 at 12:21 PM with the Maintenance Supervisor, revealed he was unaware the panels were left unlocked and was aware the panels were to be locked when residents could access them.	K 147			

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K 147	Continued From page 2 The census of fifty-five (55) was verified by the Administrator on 07/24/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 07/24/14. Actual NFPA Standard: Reference: NFPA 70 (1999 edition) 110-31 (a) Indoor Installations (1) In Places Accessible to Unqualified Persons, In-door electrical installations that are open to unqualified persons shall be made with metal-enclosed equipment or shall be enclosed in a vault or in an area to which access is controlled by a lock. Metal-enclosed switchgear, unit sub-stations, transformers, pull boxes, connection boxes, and other similar associated equipment shall be marked with appropriate caution signs. Openings in ventilated dry-type transformers or similar openings in other equipment shall be designed so that foreign objects inserted through these openings will be deflected from energized parts.	K 147	4) The Maintenance Supervisor will check the electrical panels on a weekly basis to ensure they are locked for 12 weeks. The results of the checks will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at least the Administrator, Director of Nursing, Assistant Director of Nursing and the Maintenance Supervisor with the Medical Director attending at least quarterly. 5) Completion date: 9/7/14	9/7/14	

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