

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

PRINTED: 02/03/2014
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 01/17/2014
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NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN STREET MORGANTOWN, KY 42261
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F 000	INITIAL COMMENTS A Recertification/Abbreviated Survey investigating #KY21182 was conducted on 01/15/14 through 01/17/14 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of an "E". #KY21182 was 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 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 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 care to residents.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. Observation of a handrail on the incline corridor revealed it would not allow a resident continuous support due to a wooden bracket that would not allow the resident to grip the area. In addition, bath basins, bedpans and urinals in rooms #112, #200, #202, #204, #209, #211, #212, and #215 were not stored in a plastic or brown bag and labeled. The findings include: Observation, on 01/16/14 at 12:25 PM, revealed the inclining hallway hand rails, near the entrance of IC-1 dining area, did not allow residents to maintain continuous hold due to a board, situated	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 2/11/14
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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 253	<p>Continued From page 1</p> <p>In the middle of the railing and on each side of the hand rails that would not allow the resident to safely get their fingers around the hand rail.</p> <p>Interview with the Maintenance Director, on 01/16/14 at 5:41 PM, revealed the hand rails would not allow the residents to maintain a continuous hold on the hand railing and could result in a possible fall.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 01/16/14 at 12:15 PM, revealed the handrails were used to assist residents to go down the incline and the residents could not get their hands around the rail at the window where the wood blocked the passage of the railing.</p> <p>Interview with the Administrator, on 01/17/14 at 4:48 PM, revealed he was not aware the hand railing was a falls risk, but would see this was remedied.</p> <p>2. Review of the facility provided standards of practice entitled, "Mosby's Textbook for Long-Term Care Nursing Assistants", 6th edition, revealed to "use leak-proof plastic bags for soiled tissues, linens, and other materials and to make sure all persons have their own personal care equipment. This includes wash basins, bedpans, urinals, commodes, and eating and drinking utensils. Do not use items that are on the floor. The floor is contaminated. Clean bedpans, urinals, and commodes after each use, follow the center's disinfection procedures".</p> <p>Observation, on 1/15/14 between 10:44 AM and 11:58 AM during the initial tour, revealed:</p> <p>A. a bath basin was not bagged and was sitting on the resident's clothes in the closet in room</p>	F 253	<p>F253</p> <ol style="list-style-type: none"> The inclining handrail near entrance of the IC-1 dining room was corrected on January 20, 2014 by the Maintenance Director to allow continuous hold on the board. The washbasins, bedpans, and urinals in rooms identified were discarded and replaced by the Assistant Director of Nursing on January 15, 2014. 100% audit of all handrails was conducted by the Maintenance Director on January 20, 2014 to ensure that elders would have continuous hold on the board. There were no other concerns identified. A 100% audit was completed by the Director of Nursing on February 11, 2014 to ensure that all bedpans, graduates, washbasins, and urinals were bagged and labeled. There were no concerns identified. The Maintenance Director was re-educated by the Administrator regarding hand rails on January 20, 2014. Nursing staff will be re-educated by the Staff Development Coordinator or the Director of Nursing that all urinals, bedpans, washbasins, and graduated cylinders should be labeled with the residents name and placed in plastic bag by February 26, 2014. 	3/1/14	

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F 253	Continued From page 2 #202 and #204. B. four (4) bath basins were in the tub and not bagged in room #212. C. two (2) graduated cylinders on the back of the toilet were not labeled and a bedpan was sitting on the floor and not bagged in room #112. Interview with Licensed Practical Nurse (LPN) #1 and Certified Nursing Assistant (CNA) #1, on 1/17/14 at 3:55 PM, revealed they had gone through the residents' rooms after surveyor observation and had identified bedpans, bath basins, and urinals were not stored in bags in rooms #200, #202, #204, #209, and #211. Interview with CNA #2, on 1/17/14 at 3:30 PM, revealed bath basins and bedpans should be stored in a bag, and in the closet when not in use. The CNA stated the graduated cylinders should be labeled with the resident's name, in a bag and stored on the back of the commode. The urinal should be labeled and stored on the lower bed rail so the resident can reach it. Interview with Staff Development Coordinator, on 1/17/14 at 4:07 PM, revealed bath basins should be stored in a bag. She stated she did not expect bath basins to be tossed in the closet or graduated cylinders not to be labeled. Interview with the Assistant Director of Nursing (ADON) for the Secure Unit/IC-1 Unit on 01/17/14 at 7:30 PM, revealed she expected the bath basins and bedpans to be stored in a plastic or paper bag.	F 253	4. The Maintenance Director will monitor all hand rails monthly x 3 months to ensure continued compliance. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Unit Manager will monitor 20 residents per week x 12 weeks to ensure that all urinals, bedpans, graduates, and bath basins are labeled and stored in plastic bags. The audit results will be reviewed by the Quality Assurance Committee monthly x 3 months. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281	Continued From page 3 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 Interim Care Plan, Resident Transfer Form, and Admission Assessment it was determined the facility failed to develop an Interim Care Plan that addressed Suicidal Gestures for one (1) of twenty four (24) sampled residents (Resident #20). Resident #20 was admitted with a history of trying to wrap a call light cord around his/her neck while at the hospital, and the facility failed to develop interventions for staff to monitor for the behavior. The findings include: Review of the Admission Assessment revealed the facility admitted Resident #20 on 01/10/14, with diagnoses which included Cerebral Vascular Accident (CVA) with left sided Hemiparesis and Depression with Suicidal Ideation. Review of the Resident Transfer Form, revealed Resident #20 was admitted to the facility from a Behavioral Health Center, where he was treated for Depression with Suicidal Ideations. Further review revealed Resident #20 was transferred to the Behavioral Health Center from the hospital where he/she had attempted to tie a call light cord around his/her neck after having CVA. Resident #20 was admitted to the Behavioral Health Center on 01/02/14 and discharged on 01/10/14, to the facility. Review of the Interim Care Plan, dated 01/10/14,	F 281	F281 1. Resident # 20 care plan was developed on January 17, 2014 by the Social Services Director to include hand bell in place of call light and consult psychiatrist. 2. 100% audit of residents will be conducted by Social Services Director by February 7, 2014 to ensure that all residents care plans are accurate and interventions appropriate. 3. The Social Services Director and all licensed nurses will be re-educated by the Staff Development Coordinator by February 26, 2014 that all residents with suicidal ideation are to have interventions upon admission and care plan developed. 4. The Director of Nursing will audit 3 new admissions per week x 12 weeks to ensure interim care plan in place and addresses suicidal gestures if needed. The audit results will be reviewed by the Quality Assurance Committee monthly x 3 months. If at any time concerns are identified, the Quality Assurance Committee will review and make further recommendations.	3/1/14

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F 281	Continued From page 4 revealed there was no care plan in place to address Resident # 20's diagnosis of Depression with Suicidal Ideations and history of attempting to wrap a call light cord around his neck/her neck. Observation of Resident #20, on 01/17/14 at 3:00 PM, revealed the resident was lying in bed with call light cord connected to his/her bedside. Interview with Assistant Director of Nurses (ADON) #2, Registered Nurse (RN) #1 and Certified Nurse Aids (CNAs) #1 and CNA #2, on 01/17/14 at 6:10 PM, 6:15 PM, and 7:40 PM respectively, revealed they were not aware of Resident 20's diagnosis of Depression with Suicidal Ideation, and, history of attempting to wrap call light cord around his/her neck. Interview with ADON #2, on 01/17/14 at 7:40 PM, revealed the resident should have been assessed on admission for signs and symptoms of depression. ADON #2 stated the admitting nurse was responsible for developing the interim care plan, but as the Unit Supervisor she was ultimately responsible. The ADON stated she would have expected the nurse to have assessed the resident for suicidal ideations and depression, developed an interim care plan to address the history of Depression with Suicidal Ideations and attempting to wrap call light cord around neck and place, and to remove anything that could be harmful to the resident.	F 281			
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	F 315			

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F 315	<p>Continued From page 6</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the face sheet, Minimum Data Set (MDS) assessment, Urinary Catheter Interdisciplinary and Certified Nurse Aide (CNA) Care Plans, laboratory report, and facility policy, it was determined the facility failed to ensure appropriate catheter care was provided to prevent urinary tract infections for one (1) of twenty-four (24) sampled residents (Resident #1).</p> <p>The findings include:</p> <p>Review of the facility policy entitled, "Catheter Care-Indwelling, dated 12/2010, revealed the "equipment needed for Foley catheter care: soap and water, gloves, bedpan, wash cloths, basin with lukewarm water, gauze sponges or cotton balls, antibiotic ointment if ordered. Under Procedural Guidelines: 4. Put lukewarm water and washcloth in basin, 7. Use soapy washcloth with soap to wash carefully around urethral meatus and adjacent catheter. For male residents: Gently ease foreskin back. If there is an accumulation of secretions, cleanse well with soapy washcloth. Squeeze warm water over the penis with foreskin retracted, then pull back down and cleanse well with solution, and squeeze warm water over two (2) to three (3) inches of</p>	F 315	<p>F315</p> <ol style="list-style-type: none"> 1. Certified Nursing Assistant #5 was re-educated by the Assistant Director of Nursing regarding urinary catheter care with return demonstration on January 16, 2014. Resident #1 was assessed for signs or symptoms of a urinary tract infection for 7 days with no concerns identified. 2. Residents with indwelling catheters were assessed for signs and symptoms of urinary tract infection by the Assistant Director of Nursing on January 24, 2014. 3. All staff providing catheter care will be re-educated regarding urinary catheter care with return demonstration by February 26, 2014 by the Staff Development Coordinator. 4. The Director of Nursing and/or designee will audit five (5) nursing staff per week providing urinary catheter care x 12 weeks to ensure that proper catheter care is provided. The audit results will be reviewed by the Quality Assurance Committee monthly x 3 months. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations. 	3/1/14

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F 315	<p>Continued From page 6 catheter.</p> <p>Review of Resident #1's face sheet revealed the facility admitted Resident #1 on 11/03/11 with diagnoses which included Parkinson's, Urinary Tract Infections (UTI), Cerebral Vascular Accident, Dementia, and Benign Prostatic Hyperplasia. Review of the quarterly MDS assessment, dated 08/20/13, revealed the facility assessed Resident #1's cognition as cognitively intact and to require extensive assist of one (1) staff with hygiene and bathing.</p> <p>Review of the CNA Care Plan, dated 01/2014 revealed Resident #1 was independent with the assist of one (1) staff PRN (as needed) with urinary catheter and leg bag; and an intervention to provided catheter care every shift and PRN.</p> <p>Observation, on 01/16/14 at 9:24 AM, revealed CNA #5 provided urinary catheter care. CNA #5 laid washcloths on the over the bed table surface and not in washbasin per the facility's policy. The CNA proceeded to pull up the resident's foreskin from the penis shaft and began washing and rinsing the resident's perineal area with the wash cloths he had laid on the over the bed table. CNA #5 then pulled up Resident #1's clothing without pulling the foreskin back down the shaft of the penis and did not clean off the over the bed table after providing the care.</p> <p>Review of a laboratory report for a urinalysis, collected 11/29/13, revealed the resident's urine was positive for Proteus Mirabilis and Providencia Stuartii with gram negative rods greater than 100,000. A laboratory report, dated 01/03/14, revealed the residents urine was positive for Proteus Mirabilis greater than 100,000. Review</p>	F 315		

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F 315	<p>Continued From page 7 of Antibiotic Care Plans, dated 11/29/13 and 01/07/13 revealed Resident #1 had a UTI and was on an antibiotic for ten (10) days and seven (7) days respectively.</p> <p>Interview with CNA #5, on 01/16/14 at 9:38 AM, revealed he had been trained to do catheter care, and should not have put wash cloths on the over the bed table without cleaning it first. The CNA stated he forgot to pull down the foreskin over the shaft of the penis on Resident #1 after providing catheter care and this could cause irritation and rashes.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 1/16/14 at 9:42 AM, revealed Resident #1 had a Urinary Tract Infection (UTI) and had just completed an antibiotic. LPN #2 stated when staff provided catheter care a wash basin should be utilized for cleaning. She stated the foreskin over the shaft of the penis should be pulled back, cleaned, and pulled down after cleaning to prevent infections.</p> <p>Interview with the Assistant Directors of Nursing (ADON) #2 and #3, on 1/16/14 at 10:44 AM, revealed when staff provide catheter care a basin with warm water and soap and wash cloths should be utilized, and a towel should be placed on the over the bed table as a barrier between the washcloth and table. ADON #2 & #3 stated the foreskin should be pulled over the shaft of the penis after providing care to prevent the tip of the penis from swelling.</p> <p>Interview with the Staff Development Coordinator (SDC), on 1/16/14 at 11:00 AM, revealed staff was trained to do catheter care by return demonstration and skill/competency check-offs</p>	F 315			

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F 315 F 371 SS=H	Continued From page 8 on hire. 483.35(i) 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 and facility policy review, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observations of the kitchen, revealed undated food items stored in the refrigerator and the drip tray on the stove lacked frequent cleaning. In addition, the lids for the dumpsters were noted to have been broken and unable to seal and the sliding, side door of the dumpster was noted to have been left opened. Two observations revealed multiple debris scattered on the ground surrounding the dumpsters. A review of the facility's census and condition, dated 01/15/14, revealed there were one-hundred and eighteen (118) residents in the facility and nine (9) of those residents were tube feeders and did not eat food from the kitchen area. The findings include:	F 315 F 371	F371 1. The undated items that were found on January 15, 2014 and January 17, 2014 were discarded by the Dietary Manager on the respective dates. The dumpster lid was repaired on January 23, 2014 by the Maintenance Director. The discarded breads and tomatoes were picked up by the Maintenance Director on January 17, 2014. The stove drip tray aluminum foil was changed on January 17, 2014 by dietary staff. 2. 100% audit of all stock was completed by the Dietary Manager on January 20, 2014 with no concerns identified. The Maintenance Director completed 100% audit of dumpsters on January 23, 2014 to ensure all were working appropriately with no concerns identified. The stove drip tray aluminum foil was changed on January 17, 2014. It is on a weekly cleaning schedule. 3. The Dietary Manager will re-educate all dietary staff regarding storage and dating of food items by March 1, 2014. All staff will be re-educated by the Staff Development Coordinator to notify maintenance of any items that are in need of repair by March 1, 2014. The Dietary Manager will re-educate all dietary members regarding the cleaning assignment by March 1, 2014.	3/2/14

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F 371	<p>Continued From page 9.</p> <p>Review of the facility "Food ordering and Receiving Policy," undated, revealed leftover food was to have been stored in covered containers or wrapped carefully and securely. Each item was to have been clearly labeled and dated before being refrigerated. Leftover food was to be used within 48 hours or discarded.</p> <p>1. An observation of freezers and refrigerators, on 01/15/14 at 11:20 AM, revealed undated items to include two (2) large bags of garlic bread, four (4) large bags of Kaiser Rolls and a loaf of Rye Bread. Observation on 01/17/14 at 3:50 PM revealed two (2) large pork roasts in the refrigerator, with no dates marked.</p> <p>Interview with the Dietary Manager, on 01/15/13 at 11:25 AM, revealed she was the one who checked the freezers and refrigerators weekly, for outdated items and was not aware of the undated food items in the refrigerators and freezers. She also stated she made daily rounds every morning and checked for outdated products but did not see these items, that morning.</p> <p>2. Observations of the dumpster area, on 01/17/14 at 3:35 PM, with the Dietary Manager, and at 3:55 PM, with the Maintenance Director, revealed the dumpster lid was broken off the top hinges and lying down inside the dumpster. Surrounding the dumpster, on the concrete, were discarded briefs, tomatoes and coffee grounds and the dumpster contained large, empty cans of vegetables, in clear bags</p> <p>Interview with the Dietary Manager, on 01/17/14 at 3:35 PM, revealed the kitchen staff did not utilize the dumpster, only the trash compactor</p>	F 371	<p>4. The Dietary Manager will audit all stock for dates two times per week for 12 weeks. The dumpster will be monitored by the Maintenance Director three times a week for 12 weeks to assess that the dumpsters are working properly and there are no debris on the ground. The Dietary Manager will monitor the weekly cleaning schedule three times per week x 12 weeks to assure that the schedule is being followed. The audit results will be reviewed by the</p> <p>Quality Assurance Committee monthly x 3 months. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations</p>	

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: 185006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/17/2014
NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 371	<p>Continued From page 10</p> <p>and she was not aware of why the doors were left open or who was responsible to ensure the debris, surrounding the containers, was properly disposed.</p> <p>Interview with the Maintenance Director, on 01/17/14 at 3:35 PM, revealed he was not made aware the dumpster lids were broken, or he would have had them fixed. He stated he would have cleaned around the dumpster, had he been made aware there was a problem. Review of the Maintenance Logs revealed no entry for these concerns.</p> <p>3. Observation of the stove drip tray, with the Dietary Manager, on 01/17/14 at 3:45 PM, revealed the aluminum foil on the tray to have been dated 01/03/14. The foil contained a large amount of oil and blackened substances. The Dietary Manager stated the drip tray should have been cleaned at least weekly and she was the one who monitored to ensure the drip trays were clean and she just failed to do this.</p>	F 371			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185006	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/16/2014
NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1972</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two (2) story, Type II (000)</p> <p>SMOKE COMPARTMENTS: Ten (10) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with (67) heat and (45) smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Two (2) Type II generators. Fuel source is natural gas and propane.</p> <p>A standard Life Safety Code survey was conducted on 01/15/14 thru 01/16/14. Morgantown Care and Rehab Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one hundred twenty two (122) beds with a census of one hundred eighteen (118) 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>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 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 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 care to residents.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X5) DATE 2/21/14

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188006	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/16/2014
NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 000	Continued From page 1 Fire)	K 000	K025	
K 025 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect nine (9) of ten (10) smoke compartments, all residents, staff and visitors. The facility is certified for one hundred twenty two (122) beds with a census of one hundred eighteen (118) on the day of the survey. The facility failed to ensure eight (8) smoke barriers were sealed around pipes and wires to resist the passage of smoke. The findings include:	K 025	1. All identified areas were equipped with fire caulk capable of maintaining the smoke resistance on 1/20/14. 2. All smoke barriers were checked by maintenance director on 1/20/14 with no other concerns identified. 3. Maintenance Director was re-educated by Administrator on 1/24/14 regarding proper smoke barrier compliance. 4. All smoke barriers will be audited for proper smoke barrier material monthly for 3 months. Findings will be brought to Quality Assurance committee for 3 months. The findings will be reviewed by the Quality Assurance team for further recommendations. If at any time concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance committee will consist of at a minimum, the Administrator, Director of Nursing, Social Services Director, Dietary Services Manager, and Medical Director at least quarterly.	2/1/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185006	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/16/2014	
NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN STREET MORGANTOWN, KY 42261		
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K 025	<p>Continued From page 2</p> <p>Observations, on 01/15/14 between 10:05 AM and 12:18 PM with the Maintenance Supervisor, revealed the smoke partitions, extending above the ceiling located at the IC2 unit, the PC unit, the vending area at the ramp, at room #230, at room # 219, at room # 210, at room # 105, and at medical records were penetrated by pipes and wires. Further observation revealed quick foam was used on a smoke wall located at room 219.</p> <p>Interview, on 01/15/14 between 10:05 AM and 12:18 PM with the Maintenance Supervisor, revealed he was unaware of the penetrations in the smoke barriers as they have been inspected several times since the last survey. Further interview revealed he was aware the smoke barriers in the attic were to be sealed around all penetrations.</p> <p>Interview, on 01/16/14 at 10:27 AM with the Administrator, revealed he has never checked on a smoke barrier in the facility. The facility has no policy on the smoke barriers and uses the Life Safety code to be in compliance.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall:</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to</p>	K 025		

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NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN STREET MORGANTOWN, KY 42261	
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K 025	Continued From page 3. penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185008	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/18/2014
NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 038	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of ten (10) smoke compartments, forty-five (45) residents, staff and visitors. The facility is certified for one hundred twenty two (122) beds with a census of one hundred eighteen (118) on the day of the survey. The facility failed to ensure one (1) egress door would open fully.</p> <p>The findings include:</p> <p>Observation, on 01/16/14 at 9:40 AM with the Maintenance Supervisor, revealed the egress door at the skilled bend exit was blocked by a car, which would not allow the door to open fully in the event of an emergency.</p> <p>Interview, on 01/16/14 at 9:40 AM with the Maintenance Supervisor, revealed the facility had problems with employees parking in this area and had installed a no parking sign on the building to try and prevent this from happening.</p> <p>Interview, on 01/16/14 at 10:27 AM with the Administrator, revealed he was unaware there was an employee's car parked in front of the exit located at the skilled bend. The facility has no policy on the blocking of an exit and uses the Life Safety code to be in compliance. Further interview revealed the facility has addressed employees parking in this area but he can't watch the exit all the time.</p> <p>Reference: NFPA 101 (2000 ed.)</p>	K 038	<p>K038</p> <ol style="list-style-type: none"> The identified vehicle was moved on 1/16/14 after it was brought to the attention of the Maintenance Director and Administrator 100% of all exit doors near parking surfaces were audited by Maintenance Director on 1/16/14 regarding proper signage. All exit door areas requiring proper signage were noted and proper signage was installed on 1/24/14. Posts blocking all parking at Skilled exit door will be installed by 3/1/14. All staff will be re-educated by Staff Development Coordinator by 2/26/14 regarding parking in only approved areas. Maintenance Director will monitor parking lot 3x per week for 3 months vehicles parked in appropriate places and presence of proper signage. Any issues will be resolved immediately and brought to Quality Assurance committee. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance committee will consist of at a minimum, the 	3/2/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

185006

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 01

B. WING

(X3) DATE SURVEY
COMPLETED

01/16/2014

NAME OF PROVIDER OR SUPPLIER

MORGANTOWN CARE & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

201 SOUTH WARREN STREET
MORGANTOWN, KY 42261

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K 038	Continued From page 5	K 038	Administrator, Director of Nursing, Social Services Director, Dietary Services Manager, and Medical Director at least quarterly.	2/22/14
K 045 SS=F	<p>7.1.10 Means of Egress Reliability. 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. NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of ten (10) smoke compartments, all residents, staff and visitors. The facility is certified for one hundred twenty two (122) beds with a census of one hundred eighteen (118) on the day of the survey. The facility failed to ensure the outside emergency lights had two (2) bulbs at seven (7) exits.</p> <p>The findings include:</p> <p>Observation, on 01/15/14 between 12:30 PM and 4:00 PM with the Maintenance Supervisor, revealed the exterior exits at the end of IC2, end of PC Hall, end of secured unit, and the smoking exit had a single light for illumination of the</p>	K 045	<p>K045 1. Emergency lights will be installed by 2/21/14 at exterior exits by Maintenance Director at the end of IC2, PC Hall, Secured unit, and smoking exit. 2. Maintenance Director completed 100% audit of all exits to ensure proper illumination on 1/24/14. No further concerns were identified. 3. Maintenance Director was re-educated by the Administrator on 1/24/14 regarding proper exit illumination. 4. All exit lights will be audited by Maintenance Director once per week for 3 months with any issues being brought to Quality Assurance committee. If at any time concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance committee will consist of at a minimum, the Administrator, Director of Nursing, Social Services Director, Dietary Services Manager, and Medical Director at least quarterly.</p>	

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K 045	Continued From page 6 outside of the exit. Further observation revealed the exterior exits at the kitchen parking lot and the side of therapy had no exterior lighting. Interview, on 01/15/14 between 12:30 PM and 4:00 PM with the Maintenance Supervisor, revealed he was unaware the lighting fixtures serving the exterior exits must include more than one bulb for illumination of the egress path. Interview, on 01/16/14 at 10:27 AM with the Administrator, revealed he was aware there was to be exterior lighting at an exit discharge but was unaware there had to be at least two bulbs serving the exit. The facility has no policy on exterior lighting and uses the Life Safety code to be in compliance. Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler	K 056	K056 1. The sprinkler heads identified in the Lobby area will be replaced with appropriate sprinkler heads by Century Fire Protection by 3/1/14. The identified closet areas will be deconstructed and replaced by mobile wardrobes by Maintenance Director by 3/1/14. 2. 100% audit of all closets within the center was completed by Maintenance Director on 1/24/14 with no	3/2/14

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NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN STREET MORGANTOWN, KY 42261	
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K 056	<p>Continued From page 7</p> <p>systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect six (6) of ten (10) smoke compartments, seventy-two (72) residents, staff and visitors. The facility is certified for one hundred twenty two (122) beds with a census of one hundred eighteen (118) on the day of the survey. The facility failed to ensure all closets of the building had proper sprinkler coverage. According to CMS S&C 13-55-LSC the enforcement implication would be a fully sprinklered facility with minor problems</p> <p>The findings include:</p> <p>Observation, on 01/15/14 between 12:30 PM and 4:00 PM with the Maintenance Supervisor, revealed the closets in the resident rooms # 229, 230, 225, 227, 228, 226, 223, 224, 222, 221, 220, 219, 217, 215, 218, 216, 214, 212, 213, 211, 210, 208, 209, 206, 207, 204, 202, 200, 201, 203, 205, 102, 100, 104, 108, 108, 110, 112, 114, 115, 113, 111, 107, and 105 did not have sprinkler protection. Further observation revealed the closets were built in the facility and the sprinkler in the room was over 5 feet from the closets.</p> <p>Interview, on 01/15/14 between 12:30 PM and</p>	K 056	<p>further concerns identified. 100% audit of all center's sprinkler heads was completed by Maintenance Director on 1/24/14 with no further issues identified.</p> <p>3. Maintenance Director will be re-educated by the Administrator regarding requirement K056 on 1/24/14.</p> <p>4. Maintenance Director will audit the center's sprinkler system once per month x 3 months to ensure proper sprinkler coverage. If at any time concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance committee will consist of at a minimum, the Administrator, Director of Nursing, Social Services Director, Dietary Services Manager, and Medical Director at least quarterly.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN STREET MORGANTOWN, KY 42261		
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K 056	<p>Continued From page 8</p> <p>4:00 PM with the Maintenance Supervisor, revealed he was not aware that the closets listed did not have proper sprinkler protection. Further interview revealed after the last survey the facility cut the top out of the closets down 8 inches to get sprinkler coverage for the closets.</p> <p>interview, on 01/16/14 at 10:27 AM with the Administrator, revealed he was unaware the closets in the resident rooms were not properly sprinklered. The facility has no policy on sprinkler coverage and uses the Life Safety code to be in compliance. Further interview revealed when the facility cut the eight inches out of the top of the closets he assumed they were in compliance with being fully sprinklered.</p> <p>Observations, on 01/15/14 at 3:25 PM with the Maintenance Supervisor, revealed standard response sprinkler heads and quick response sprinkler heads in the same compartment, located in the lobby of the facility. This deficiency would not allow both sprinkler heads to engage at the same heat level.</p> <p>Interview, on 01/15/14 at 3:26 PM with the Maintenance Supervisor, revealed the facility had the high up sprinklers all changed since the last survey to have the same response time. Further interview revealed he was unaware the standard response heads in the overhangs of the corridor in the lobby area must also meet the same response time of the higher up sprinklers in the same compartment.</p> <p>Interview, on 01/16/14 at 10:27 AM with the Administrator, revealed he was unaware the sprinklers in the lobby area were not properly installed to have the same response time. The</p>	K 056		

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NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN STREET MORGANTOWN, KY 42261	
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K 056	<p>Continued From page 9 facility has no policy on sprinkler response times and uses the Life Safety code to be in compliance.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>6-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101; 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of</p>	K 056		

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NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN STREET MORGANTOWN, KY 42281	
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K 056	Continued From page 10 operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 056		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not	K 066		

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NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN STREET MORGANTOWN, KY 42261		
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K 066	<p>Continued From page 11 responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation, smoking policy review, and interview, it was determined the facility failed to ensure the use of approved smoking areas, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of ten (10) smoke compartments, thirty (30) residents, staff and visitors. The facility is certified for one hundred twenty two (122) beds with a census of one hundred eighteen (118) on the day of the survey. The facility failed to ensure employees were smoking only in a designated smoking area.</p> <p>The findings include:</p> <p>Observation, on 01/15/14 at 3:24 PM with the Maintenance Supervisor, revealed the area at the courtyard exit was being used as a smoking area due to all the cigarette butts on the ground and in the metal bucket at the exit. The area did not provide an approved ashtray and is not listed as a smoking area at the facility.</p>	K 066	<p>K066</p> <ol style="list-style-type: none"> Proper signage was immediately placed in identified area. Approved ashtray was placed at courtyard exit on 2/12/14 by Maintenance Director. Fire extinguisher and fire blanket was installed at the exit on 2/12/14. 100% audit of all smoking areas was conducted for proper smoking equipment by Maintenance Director on 2/12/14 with no further concerns identified. Maintenance Director was re-educated by Administrator on 1/27/14 regarding proper smoking equipment at designated smoking areas. Maintenance Director will audit identified area once per month x 3 months to ensure proper smoking procedures are being followed. Any issues noted during weekly audit will be brought to Quality Assurance committee. If at any time concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance committee will consist of at a minimum, the Administrator, Director of Nursing, Social Services Director, Dietary Services Manager, and Medical Director at least quarterly. 	2/2/14	

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K 066	<p>Continued From page 12</p> <p>Smoking Policy Review, on 01/15/14 at 3:24 PM with the Maintenance Supervisor, revealed employees shall be allowed to smoke in the designated EMPLOYEE smoking area. This area may also be designated for guests and visitors as well.</p> <p>Interview, on 01/15/14 at 3:24 PM with the Maintenance Supervisor, revealed he was unaware of the smoking occurring at the exit to the courtyard.</p> <p>Interview, on 01/16/14 at 10:27 AM with the Administrator, revealed he was aware there was smoking occurring at the gazebo in the courtyard which is not the dedicated employee smoking area but was unaware of the cigarette butts being placed at the courtyard exit. He was aware the smoking policy stated employees and guests could only smoke in the dedicated employee smoking area. Further interview revealed the smoking area was located across from medical records outside the side exit door..</p> <p>Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the International symbol for no smoking.</p>	K 066		

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K 066	Continued From page 13 Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. NFPA 101 LIFE SAFETY CODE STANDARD	K 066		
K 069 SS=F	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on Kitchen hood inspection records and interview, the facility failed to ensure the kitchen hood system was in accordance with NFPA standards. The deficiency had the potential to affect one (1) of ten (10) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty two (122) beds with a census of one hundred eighteen (118) on the day of the survey. The facility failed to ensure the kitchen hood suppression system was	K 069	K069 1. Kitchen hood was inspected by qualified professionals on 1/17/14. Kitchen hood will be inspected semi-annually. Documentation will be kept by maintenance supervisor.	

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NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN STREET MORGANTOWN, KY 42261	
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K 069	<p>Continued From page 14 inspected semi-annually.</p> <p>The findings include:</p> <p>Record review, on 01/16/14 at 8:30 AM with the Maintenance Supervisor, revealed there was no documentation of a kitchen hood inspection being performed since 4/8/2013.</p> <p>Interview, on 01/16/14 at 8:30 AM with the Maintenance Supervisor, revealed he was under the impression the proper inspection was completed in October of 2013.</p> <p>Interview, on 01/16/14 at 10:27 AM with the Administrator, revealed he was under the impression the kitchen hood was to be inspected annually at the facility. The facility has no policy on kitchen hood inspections and uses the Life Safety code to be in compliance. Further interview revealed the facility had changed kitchen hood inspection companies and there was a mix up on when the last inspection was performed.</p> <p>Reference: NFPA 10 (1998 Edition).</p> <p>2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.</p> <p>Reference: NFPA 96 (1998 ed.)</p> <p>8-3 Cleaning. 8-3.1* Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent</p>	K 069	<p>2. Identified kitchen hood is sole hood in the center.</p> <p>3. Maintenance Director was re-educated by Administrator on 1/22/14 regarding timeliness of kitchen hood inspection</p> <p>4. Inspection records will be audited by Maintenance Director once every 6 months to ensure proper compliance.</p> <p>Any identified issues resulting from records audit will be brought to the Quality Assurance committee. If at any time concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance committee will consist of at a minimum, the Administrator, Director of Nursing, Social Services Director, Dietary Services Manager, and Medical Director at least quarterly.</p>	2/1/14

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K 069	Continued From page 15 Intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a Extinguishers, properly trained, qualified, and certified company or person acceptable to the authority having jurisdiction in accordance with Table 8-3.1. Table 8-3.1 Exhaust System Inspection Schedule Type or Volume of Cooking Frequency Systems serving solid fuel cooking operations Monthly Systems serving high-volume cooking operations Quarterly such as 24-hour cooking, charbroiling or wok cooking Systems serving moderate-volume cooking Semiannually operations Systems serving low-volume cooking operations, such Annually as churches, day camps, seasonal businesses, or senior centers	K 069		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free	K 072		

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K 072	<p>Continued From page 16</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect three (3) of ten (10) smoke compartments, thirty (30) residents, staff and visitors. The facility is certified for one hundred twenty two (122) beds with a census of one hundred eighteen (118) on the day of the survey. The facility failed to ensure wheelchairs, tables, and 32 gallon trash cans were properly stored out of the corridor when not in use.</p> <p>The findings include:</p> <p>Observation, on 01/15/14 between 12:30 PM and 4:00 PM with the Maintenance Supervisor, revealed two (2) wheelchairs and two (2) 32 gallon trash cans stored in the corridor, along one side of the corridor, on 1C2. Further observation revealed the 32 gallon trash cans stored in the corridors of the skilled unit and the skilled hall.</p> <p>Interview, on 01/16/14 between 12:30 PM and 4:00 PM with the Maintenance Supervisor, revealed the facility routinely stored the trash cans in the corridor for easier access to them. He was under the impression that if they all storage on one side of the corridor they were</p>	K 072	<p>K072</p> <ol style="list-style-type: none"> 37 gallon barrels were immediately placed in unit shower rooms on 1/15/14 by Maintenance Director. Wheel chairs identified were placed in resident rooms by Maintenance Director on 1/15/14. 100% audit of all floors within the center was completed on 1/15/14 by the Maintenance Director to ensure proper storage requirement were met. All staff will be educated by Staff Development Coordinator by 2/26/14 regarding proper storage in the corridors. Corridors will be audited once a week for 3 months by Maintenance Director regarding proper storage of barrels and wheelchairs. Any issues will be brought to the Quality Assurance Committee. If at any time concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance committee will consist of at a minimum, the Administrator, Director of Nursing, Social Services Director, Dietary Services Manager, and Medical Director at least quarterly. 	3/1/14

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K 072	Continued From page 17 following the code. Interview, on 01/16/14 at 10:27 AM with the Administrator, revealed he was aware there could no storage in the corridors over the 30 minutes. The facility has no policy on storage in the corridor and uses the Life Safety code to be in compliance. Further interview revealed he was unaware the 32 gallon trash cans could not be stored in the corridors. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 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.	K 072		