

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

PRINTED: 06/20/2011
FORM APPROVED
OMB NO. 0938-0391



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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 C 06/08/2011 |
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| NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 206 SOUTH WARREN STREET MORGANTOWN, KY 42261 |
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| F 000 | INITIAL COMMENTS AMENDED Abbreviated surveys (KY #16358 & #16048) were conducted on 06/07/11-06/08/11 to determine the facility's compliance with Federal Regulations. KY #16358 was unsubstantiated with no deficiencies identified. KY #16048 was substantiated with deficiencies cited and the highest S/S of "D". | F 000 | Morgantown Care and Rehab Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a wavier of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations or compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure physician's orders were followed for one resident, (#2), in the selected sample of five. The facility failed to ensure implementation of a pressure alarm and a sensor alarm, to be applied to the resident's wheel chair and bed and failed to monitor the function of the alarm every shift. Findings include: A record review revealed Resident #2 was admitted to the facility, on 06/29/09, with diagnoses to include Spastic Gait, Encephalopathy at Age Two, Seizures and Progressive Deteriorating Brain Disease. A review of the quarterly assessment, dated | F 281 | 1. Resident #2's pressure alarm was replaced on 06/07/11. Proper functioning and placement was verified by the Assistant Director of Nursing on 06/07/11 and by the Director of Nursing on 06/08/11. 2. A 100% audit was completed by the Assistant Director of Nursing on 06/07/11 to ensure that every resident with a physician's order for an alarm had the alarm in place. | 6/24/11 |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jessie Clark</i> | TITLE N/A | (X6) DATE 6/22/11 |
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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 281 | <p>Continued From page 1</p> <p>04/12/11, revealed the facility assessed Resident #2 required the extensive assistance of two staff members for all activities of daily living (ADLs.) A review of the monthly physician orders, dated June 2011, revealed an order for a pressure alarm to be used at all times, initiated on 02/02/10, and a sensor alarm to the wheel chair, initiated on 01/27/11.</p> <p>A review of the Falls Risk Assessment, dated 12/28/10, revealed the facility identified Resident #2 as a high risk for falls. A review of the falls care plan, dated 04/21/11, and the Certified Nurse Aide (CNA) care plan, dated June 2011, revealed interventions included a pressure type alarm to be utilized at all times, to include when the resident was in bed and in the wheel chair to alert staff members of attempts to transfer unassisted. A review of the Change of Condition Forms, dated 12/26/10 and 12/28/10, revealed Resident #2 had a history of falls, which occurred when the resident slid out of the wheel chair onto the floor, yet received no injuries.</p> <p>An observation in Resident #2's room, on 06/07/11 at 12:00 PM, revealed the alarm box had no connecting wires and was on the floor, next to the bed and floor mats. An observation of the resident in the wheel chair, being propelled by a staff member to the dining room, on 06/07/11 at 12:10 PM, revealed there were no alarms attached to the wheel chair.</p> <p>An observation in the resident's room, on 06/07/11 at 2:35 PM, accompanied by the Director of Nurses (DON) revealed the DON stated there was "something wrong with the wires on the alarm box." The resident was seated in</p> | F 281 | <p>3. All physician's orders for alarms have been clarified with instructions regarding type of alarm, verification for placement, verification for functioning and have been put on the Medication Administration Record (MAR), the comprehensive care plan updated and the C.N.A. care plan updated on 06/20/11 by the Director of Nursing, Education regarding alarm placement provided to staff by the Assistant Director of Nursing on 06/07/11, and by the Staff Development Coordinator on 06/08/11 and 06/09/11. Alarm placement and functioning will be verified by the Director of Nursing, or designee, 5 days a week for 4 weeks to ensure compliance with alarm orders. All new orders will be reviewed by the Director of Nursing, or designee, during clinical meeting to identify any new alarm orders.</p> <p>4. Above stated audits will be reviewed by the Quality Assurance committee monthly for 3 months for further recommendations as indicated.</p> | |

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| F 281 | <p>Continued From page 2</p> <p>the wheel chair on the hallway and no alarms were observed on the wheel chair.</p> <p>An interview with the Assistant Director of Nurses (ADON), on 06/07/11 at 2:42 PM, revealed the resident, "pulls on the alarm box". The ADON stated she "had good intentions to go downstairs and get a new alarm for the resident."</p> <p>An interview, on 06/08/11 at 3:00 PM and 3:10 PM, with Resident #2's two siblings revealed both visited weekly at different times and neither had seen the alarm on the resident's bed or wheel chair, "for some time." When the siblings had asked the Certified Nurse Aides (CNAs) why the resident no longer had the alarm, one CNA had stated the wheel chairs had just been washed and she was unsure where the alarms had been placed. Both siblings stated this had occurred several weeks prior to the interview.</p> <p>A review of the Falls Policy, dated December 2010, revealed the bed and wheel chair alarms were environmental measures, used as strategies for fall reduction, but did not address proper and timely application of the devices, monitoring for the effectiveness of the device or replacement of the devices, as needed.</p> | F 281 | | |