

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

PRINTED: 03/06/2012  
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  C 02/21/2012
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NAME OF PROVIDER OR SUPPLIER  MORGANFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH CARRIER ST. MORGANFIELD, KY 42437
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F 000	INITIAL COMMENTS  An abbreviated survey (KY #17876) was initiated on 02/17/12 and concluded on 02/21/12. KY #17876 was substantiated with deficiencies cited at the highest S/S of a "G."	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 (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	F 157 NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  1) The physician for Resident #1 was notified by the facility Clinical Reimbursement Coordinator on 3/9/12 of all labs drawn in the center for Resident # 1 and the results of those labs and if the physician wished any further orders. Further lab work was ordered.  2) A 100% audit of all current resident records will be completed by the Director of Nursing, the Assistant	3/26/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mary L. Wood</i>	TITLE <i>Admin</i>	(X6) DATE <i>3/16/12</i>
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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 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, review of the facility's policy/procedure, and hospital record reviews, it was determined the facility failed to ensure the physician received, was aware and responded to a notification of a resident's significant change in status for one resident (#1), in the selected sample of three residents. The facility failed to follow their "Notification of Resident Change in Condition" policy. On 01/26/12 the facility received a laboratory (lab) result regarding renal function for Resident #1. The lab value was a test for Blood, Urea, Nitrogen (BUN) of 119 (normal value 7-18 mg/dl) and Creatinine level of 3.6 (normal value 0.8-1.4 mg/dl), both values were critically elevated. While the facility notified the physician regarding multiple lab results on 01/26/12, the facility failed to ensure the attending physician was aware of the elevated BUN and Creatinine levels and failed to ensure the physician responded to those critical labs, per the facility's "Notification of Resident Change in Condition" policy. On 02/07/12, the facility transferred Resident #1 to the local hospital having symptoms of nausea and vomiting. The hospital admitted the resident with nausea, vomiting, blood in his/her urine and having a BUN of 166 and a resulting diagnoses of Acute and Chronic Renal Failure.</p> <p>The findings include:</p> <p>A review of the facility's policy and procedure, "Notification of Resident Change in Condition," last revised August 2009, revealed the Licensed</p>	F 157	<p>Direct of Nursing and the District Education and Training Director by 3/17/2012 to assure that all abnormal labs in the past thirty (30) days have had physician notification and a physician response. All identified as not having physician notification and appropriate response will have immediate physician notification with response. A 100% audit of all current resident records will be completed by the Director of Nursing, the Assistant Director of Nursing and District Education and Training Director by 3/17/2012 to identify any change in resident condition without physician notification and response. Any identified will have immediate physician notification and response.</p> <p>3) All licensed nursing staff will be re-educated on the facility policy on "Notification of Resident Change in Condition" and the facility laboratory tracking log. This education will be provided by the District Education and Training Director, the Director of Nursing or the Assistant Director of Nursing and will be completed by 3/17/12 with no licensed staff working past 3/17/12 without having received this education.</p> <p>4) The Director of Nursing or the Assistant Director of Nursing will audit ten (10) resident records per week for twelve (12) weeks to assure any change in condition has had physician notification and response. The results of these audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time the concerns are identified, the facility will</p>	

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F 157	Continued From page 2 Nurse will immediately inform the resident's physician in the event of a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental or psychosocial status in either life-threatening conditions or complication.) Clinical complications are such things as delirium and/or onset of depression. A significant change in a life threatening situation, i.e., heart attack or stroke, etc, emergency services will be contacted for immediate transport. For a significant change that does not require immediate medical intervention, the physician will be notified immediately and the facility would expect a response in one hour. If no response was received, in one hour, the facility was to make another attempt to contact the physician and if no response was received, in one hour, the facility would contact the Medical Director. The facility would expect a response from the Medical Director within 30 minutes. If no response was received, the facility would contact emergency services. In a non-significant change in condition that does not require immediate physician interventions, the Licensed Nurse would have placed one initial notification call to the attending physician. The date and time of the call would be documented on the 24 hour report sheet daily. Logged calls, identified as not having a physician's response, would result in the Licensed Nurse placing a second call to the attending physician. If no response was received from the attending physician by the end of business day, the Medical Director would be notified.  A review of multiple laboratory values obtained at the hospital, dated from 12/08/11 through 12/15/11, prior to the resident's admission to the	F 157	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, the Administrator with the Medical Director attending at least quarterly. 5) Correction date 3/26/12	

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F 157	<p>Continued From page 3</p> <p>nursing facility, revealed the resident's BUN measured between 15-28 mg/dl (normal value 7-18 mg/dl), and the Creatinine level measured between 1.3-1.6 mg/dl (normal value 0.8-1.4 mg/dl).</p> <p>A record review revealed Resident #1 was admitted to the facility on 12/15/11 with diagnoses to include Type Two (II) Diabetes Mellitus, Chronic Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD.) A review of the "Nutritional Risk" care plan, dated 12/21/11, revealed the resident was on diuretic therapy detailing the resident was receiving the medication Bumex, with a goal for the resident to be free of dehydration. Interventions included monitoring for signs and symptoms of dehydration and "monitor labs, [as needed]."</p> <p>A review of the admission Minimum Data Set (MDS), dated 12/22/11, revealed the facility assessed the resident as moderately cognitively impaired and required the extensive assistance of two staff members with bed mobility, transfers, dressing, hygiene and bathing and the extensive assistance of one staff member for eating.</p> <p>A review of the laboratory (lab) values, dated 01/26/12, revealed the resident's BUN level was "High," with a result of 119 milligrams per deciliter (mg/dl), and the Creatinine level was "High," with a result of 3.6 mg/dl. A review of the nursing notes, dated 01/26/12 at 12:00 PM, revealed the laboratory results were received and the physician was "aware, awaiting orders." Record review revealed on 01/27/12 physician orders were received for an antibiotic related to the Urinary Analysis which detailed the resident had a</p>	F 157		

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F 157	<p>Continued From page 4</p> <p>Urinary Tract Infection; however, there were no other entries regarding the lab and no new physician orders regarding the BUN and Creatinine levels. There was no documented evidence after 01/26/12 that the facility made any further attempts to have the physician address the critical lab values related to the BUN/Creatinine.</p> <p>An interview with Certified Nurse Aide (CNA) #1, on 02/21/12 at 10:30 AM, revealed the resident experienced nausea and vomited a moderate amount of "watery, yellow" emesis and had blood in his/her urine on 02/07/12 at approximately 12:00 PM.</p> <p>A review of a nursing note, dated 02/07/12 at 11:45 AM and 12:45 PM, revealed the resident received Ativan 0.5 mg by mouth for shaking and anxiety. At 3:45 PM, the facility notified the physician regarding blood in the resident's urine. The physician ordered the resident be sent to the hospital for evaluation and treatment. The facility transferred the resident to the hospital at approximately 4:00 PM. A review of the initial Emergency Room visit, dated 02/07/12, and resulting laboratory tests revealed a BUN of 166 and a Creatinine value of 5.7. The resident was admitted to the hospital and treated for Chronic and Acute Renal Failure.</p> <p>An interview with the Director of Nursing (DON,) on 02/21/12 at 12:25 PM, revealed the physician "was made aware" of the elevated BUN and Creatinine levels on 01/26/12 at 12:00 PM. The physician responded on 01/27/12 at 5:30 PM with orders for the treatment of the Urinary Tract</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>Infection (UTI); however, there was no documented response for treatment or further orders regarding the elevated BUN/Creatinine levels. The DON stated the licensed nurse should have been aware that the physician addressed the UTI, but not the BUN/Creatinine levels, and the physician should have been notified immediately. The elevated labs should have been placed on the 24-hour report as well as the lab tracking sheet and should have been monitored closely.</p> <p>An interview with Physician #1, on 02/21/12 at 2:03 PM and 5:03 PM, revealed "a BUN of 119 would have been a panic value" and the physician stated he was not made aware of the resident's results. When reviewing the U/A, he did not review the accompanying BUN/Creatinine values and "just missed it," stating the back-up system of calls from the hospital and the facility would usually have helped keep this from happening, but there were no calls to follow-up on the labs. The physician stated if he had been made aware of the "panic levels" of the BUN/Creatinine he "would have [ordered the resident be] sent out to the hospital and admitted." He further revealed the elevated BUN would cause the nausea and vomiting.</p>	F 157			