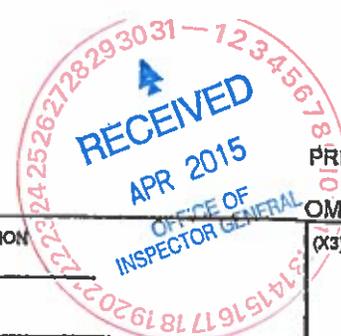


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 03/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2015
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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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(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 000	INITIAL COMMENTS	F 000	Morgantown Care and Rehabilitation 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 the right 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 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 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator DATE 4/3/15

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 278	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review and review of the Minimum Data Set (MDS) manual (CMS's RAI Version 3.0 Manual), it was determined the facility failed to code the MDS correctly related to weight gain for one (1) of nineteen (19) sampled residents (Resident #2).</p> <p>The findings include:</p> <p>Review of the CMS's RAI Version 3.0 Manual revealed if a resident had experienced a weight gain of five percent (5%) or more in the last thirty (30) days or ten percent (10%) or more in the last one-hundred and eighty (180) days and the weight gain was not planned and prescribed by a physician then it would be coded a two (2) which would indicate the resident had a 10% or more weight gain in the last 180 days.</p> <p>Record review revealed the facility admitted Resident #2 on 01/24/13 with diagnoses which included Diabetes Mellitus and Hypertension.</p> <p>Review of Resident #2's Registered Dietician's (RD) Annual Data Collection/Evaluation of Nutrition, dated 09/18/14, revealed Resident #2 had a 10% weight gain in 180 days; however, review of the annual MDS assessment, dated 09/19/14 revealed Section K0310 for weight gain revealed the resident was coded a "0" for weight gain, indicating the resident had no weight gain.</p> <p>Interview with the Dietary Manager (DM), on 03/12/15 at 8:40 AM, revealed the coding on the MDS for Section K0310 was inaccurately coded. The DM stated Resident #2 had a 10% weight gain over a 180 days and Section K0310 should</p>	F 278	<p>F 278</p> <ol style="list-style-type: none"> 1. The MDS dated 9/19/14 for resident #2 was modified by the MDS coordinator on to reflect the weight gain. 2. The Dietary Manager and MDS coordinator will review all MDS section K for elders with significant weight gain or weight loss to ensure accurate coding by 4/15/15. 3. The Dietary Manager will be reeducated by Licensed Dietician regarding MDS and definition/coding of significant weight gain in section K by 4/15/15. 4. The Interdisciplinary team will audit 5 MDS section K submissions per week x 12 weeks to assess for accuracy of MDS. 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 minimum, the Administrator, Director of Nursing, Social Services Director, and Medical Director at least quarterly. 	4/16/15

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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		
(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 27B	Continued From page 2 have been coded as a two (2) to reflect the weight gain. The DM revealed the RD provides the assessment and information for coding the comprehensive MDS assessments and the DM provides the information for the quarterly assessments. Interview with RD, on 03/12/15 at 1:00 PM, revealed the coding on the MDS was inaccurately coded. The RD stated Resident #2 had a 10% weight gain over a 180 day period and Section K0310 should have been coded as a two (2) to reflect the weight gain. Interview with the MDS Coordinator, on 03/12/15 at 8:30 AM, revealed the coding for Section K0310 was inaccurately coded. The MDS Coordinator stated Resident #2 had a 10% weight gain over a 180 day period and section K0310 should have been coded as a two (2), to reflect the weight gain. The MDS Coordinator stated the DM was responsible for coding Section K.	F 27B			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280			

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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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F 280	Continued From page 3 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to revise the comprehensive nutritional care plan regarding the problem statement, goals and interventions for one (1) of nineteen (19) sampled residents (Resident #2). Resident #2 experienced a ten percent (10%) weight gain in 180 days and the care plan and interventions were not revised to reflect these changes. The findings include: Review of facility care plan policy dated October 2010 revealed an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, (psychological needs) should be developed for each resident. Each resident's comprehensive care plan was designed to reflect treatment goals, timetables and objectives in measurable outcomes. Further review revealed the interdisciplinary team was responsible for reviewing and updating the care plans when there had been a significant change in the resident's condition; when the desired outcome was not met; when the resident has been readmitted to	F 280	F 280 1. Resident #2 care plan was updated by the Dietary Manager on to reflect weight gain and interventions. 2. All dietary care plans will be reviewed by Dietary Manager to ensure interventions and goals are accurate by 4/15/15. 3. The Dietary Manager will be reeducated by the Administrator regarding care plans to include measurable objectives, problem statements goals, and interventions by 4/10/15. 4. The dietary care plans of residents with weight gain/weight loss will be reviewed in nutrition at risk weekly and changes/updates made as needed. The Administrator will audit 5 charts per week to assess for care plan accuracy x 12 weeks. 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 minimum, the Administrator, Director of Nursing, Social Services Director, and Medical Director at least quarterly.	4/16/15	

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F 280	<p>Continued From page 4</p> <p>the facility from a hospital stay; and, at least quarterly.</p> <p>Record review revealed the facility admitted Resident #2 on 01/24/13 with diagnoses which included Diabetes Mellitus and Hypertension.</p> <p>Review of the Registered Dietician's (RD) Data Collection/Evaluation Tool, dated 09/18/14, revealed the resident's snacks were frequently in the room and excessive snacking in the room was part of the rationale for the noted excessive weight gain. However, review of Resident #2's Nutrition Care Plan for a weight gain of 10% over six (6) months, dated 09/18/14, revealed there were no interventions to address the excessive snacking.</p> <p>Further review of the Nutrition Care Plan revealed a goal to remain within a range of plus or minus three (3) pounds of the current weight through next review; however, review of the resident's weight record revealed the resident's weight of 237 pounds on 09/18/14 increased to 245.4 pounds in December 2014. There were no interventions added to address the resident's continued weight gain and the resident's goal was not revised.</p> <p>Observation and interview with Resident #2, on 03/11/15 at 8:00 AM, revealed there were multiple boxes of various snacks in his/her room and the resident stated the snacks were his/her personal snacks which included chips, crackers and snack cakes along with soda.</p> <p>Interview with the Dietary Manager (DM), on 03/12/15 at 12:35 PM, revealed the Registered Dietician (RD) implemented the care plan and</p>	F 280			

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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 280	Continued From page 5 reviewed the care plan with all annual and comprehensive assessments and the DM reviewed them with quarterly assessments. Interview with RD, on 03/12/15 at 1:00 PM, revealed the DM attended the care plan meetings but the RD completes the care plans for weight gains and losses. The RD stated sometimes the Assistant Director of Nursing (ADON) updated the care plans. Interview with Director of Nursing (DON), on 03/13/15 at 2:45 PM revealed she expected the care plans to have been updated quarterly and with any change of conditions and stated the MDS Coordinator was responsible for monitoring and updating care plans quarterly and annually.	F 280			
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 interview, record review, facility policy review and review of the Kentucky Board of Nursing (KBN) Advisory Opinion Statement (AOS) #14, it was determined the facility failed to ensure professional standards of quality were provided for one (1) of nineteen (19) sampled residents (Resident #2). Resident #2 was ordered an antibiotic twice a day for seven days (total of fourteen (14) doses); however, review of the Medication Administration Record (MAR) revealed the antibiotic was not discontinued until after the resident received sixteen (16) doses.	F 281			

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F 281	Continued From page 6 The findings include: Review of the KBN AOS #14 Patient Care Orders, last revised 10/2010, revealed licensed nurses should ensure medications are prepared and administered according to the physician's order. Review of the facility's policy titled "Medication and Treatment Orders", dated January 2014, revealed orders not specifying number of doses, or duration of medication shall be subject to automatic stop orders. Drugs not specifically limited to duration of use and number of doses when ordered will be controlled by automatic stop orders. One (1) day prior to the stop date the order is to become effective, the nurse supervisor/charge nurse on duty must contact the prescriber or attending physician to determine if the medication is to be continued. Record review revealed the facility admitted Resident #2 on 01/24/13 with diagnoses which included Diabetes Mellitus and Hypertension. Review of the Physician Order, dated 03/02/15 at 1:30 PM, revealed an order for Resident #2 to receive Augmentin (antibiotic) 875 milligrams (mg), one (1) tablet by mouth, twice a day for seven (7) days, for Upper Respiratory Infection. Review of the March 2015 MAR revealed the Augmentin had been initiated as administered twice a day for eight (8) days instead of seven (7) day per the physician's order. Interview with the Assistant Director of Nursing (ADON), on 03/11/15 at 12:00 PM revealed she	F 281	F 281 1. Resident #2 was observed for signs or symptoms of adverse reaction. The MD and elder were notified that 2 extra doses of the antibiotic was given. There were no concerns noted and no orders received. 2. All elders with antibiotics ordered on 3/2/15 were reviewed and EZ Mar reviewed for order accuracy. There were no concerns identified. 3. All licensed nurses will be re-educated by the Staff Development Coordinator in regards to medication administration and medication order input by 4/15/15. 4. The Assistant Director of Nursing for each wing will audit 5 antibiotics orders per week to assure accuracy in the EZ mar system for 12 weeks. 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 minimum, the Administrator, Director of Nursing, Social Services Director, and Medical Director at least quarterly.	4/16/15	

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F 281	Continued From page 7 was made aware of the medication error on 03/11/15. The ADON stated the antibiotic order was for seven (7) days but had been given for (8) days. The ADON revealed she expected medications to be administered according the duration specified in the physician's order. Interview with Director of Nursing (DON), on 03/13/15 at 2:45 PM, revealed she expected licensed staff to follow the physicians' orders precisely and stop the orders per the physicians' orders as directed. The DON stated the licensed staff should have put stop dates in the Electronic Medication Administration Records (E-MAR).	F 281		
F 371 SS=E	483.35(l) 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 record review, it was determined the facility failed to ensure food was stored, prepared and distributed under sanitary conditions. Observations on 03/11/15 revealed the range hood with a build up of a rust colored substance; blackened, raised areas around the base of the walk-in freezer and	F 371	F 371 1. Range hood was immediately cleaned by dietary staff on 3/12/15. Range hood will be painted by Maintenance Director by 4/15/15. Walk-in freezer was cleaned on 3/12/15 by dietary staff to remove all blackened substances. Freezer ceiling, floor, and pipe were de-iced on 3/16/15. Contracted vendor will be contacted by 4/10/15 to inspect freezer to locate root cause of ice build-up on pipe and to resolve the issue. Contractor was contacted on 3/13/15 to provide estimate for installing concrete foundation for dumpsters, compactor, and grease trap. Sliding doors on dumpsters were immediately closed by staff on 3/11/15. Build-up of debris under compactor was immediately removed by Maintenance Director on 3/12/15. Crusty debris was removed from top of convection oven on 3/11/15 by dietary staff. Professional floor technician was contacted on 4/13/15 to schedule repairing of broken tile. Kitchen tile grout was cleaned by dietary staff on 3/11/15. Professional floor technician was contacted on 4/13/15 to schedule the tile floor to be cleaned.	4/26/15

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F 371	<p>Continued From page 8</p> <p>refrigerator gaskets; the walk-in freezer was noted to have frozen condensation on the ceiling, a patch of ice on the freezer floor and an overhead pipe; two dumpsters, a compactor and an oil pit were not on a solid foundation, sliding doors on the two dumpsters were opened and there was a build-up of debris under the compactor; brown, crusty debris on top of the convection oven; tiles were broken, cracked and/or missing throughout the kitchen and storage areas and were noted to have had a visible build-up of a blackened substance around the grouted areas.</p> <p>Review of the facility's Census and Condition, dated 03/10/15, revealed there were one-hundred and sixteen (116) residents in the building and six (6) residents who received tube feedings.</p> <p>The findings include:</p> <p>Interview with the Dietary Manager (DM), on 03/11/15 at 12:05 PM, revealed there was no policy on the cleaning of the kitchen floors, equipment, freezers, or refrigerators and only assignment sheets to show this had been completed. The DM stated there was no policy on the closing of the dumpster sliding doors or maintenance of that area.</p> <p>Observation during the initial tour of the kitchen on 03/11/15 at 11:45 AM revealed the following:</p> <ol style="list-style-type: none"> 1. The range hood was noted to have a build-up of a rust colored substance, directly over the stove top. 2. The walk-in freezer and refrigerator gaskets were noted to have had a blackened substance 	F 371	<p>2. Dietary Manager will add range hood inspection to weekly cleaning forms by 4/10/15. The walk-in freezer was cleaned on 3/11/15 by dietary staff and will be added to weekly cleaning schedule by 4/10/15. Condensation on ceiling and ice of floor of walk-in freezer were removed on 3/11/15 by dietary staff. Bowling Green Refrigeration was contacted on 4/13/15 to schedule inspection of gaskets and seals for proper functioning. Professionals will install concrete to ensure soled foundation for dumpsters, compactor, and grease trap by 4/24/15. Dumpster doors were immediately closed by dietary staff on 3/11/15. Debris under compactor was removed by Maintenance Director on 3/12/15. Monitoring of the waste disposal area will be added to dietary staff daily checklist by 4/10/15. Crusty debris on top of convection oven was removed on 3/11/15 by dietary staff. Cleaning the top of the convection oven will be added to the daily cleaning schedule by 4/10/15.</p>	

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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		
(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)	(X6) COMPLETION DATE	
F 371	<p>Continued From page 9</p> <p>on the bottom of the gaskets and a blackened build-up on the tiles, grout, around the doorways. A patch of ice was noted on the freezer floor, underneath the two (2) inch wrapped pipe which had four (4) inches of ice build-up around the bend of the pipe.</p> <p>3. The area beneath the two dumpsters, a compactor and an oil pit was graveled and had a build-up of debris and wet, gray matter, underneath the compactor. All four of the sliding doors on the dumpsters were opened.</p> <p>4. A build-up of brown, crusty debris was noted on top of the convection oven, where two trays of food items for the noon meal were sitting.</p> <p>5. Throughout the kitchen and storage areas there were broken, cracked or missing tiles and the grout was noted to have a thick build up of a blackened substances.</p> <p>Interview with the Dietary Manager on 03/11/15, at the time of the observation, revealed she was not aware of the rust colored substance on the range hood and stated the hood vents were periodically cleaned but was unsure the last time the inside of the hood and over the stove top, had been cleaned and this was not on the cleaning assignment sheets. She stated the refrigerator and freezer gaskets were blackened on the bottom, due to the build-up of blackened substances on the grout and tile, below the gasket and the refrigerator and freezer seals sweep the blackened substances back and forth each time the doors are opened. She revealed the dietary staff members were aware of the need to keep the dumpster lids closed, but she was not aware the dumpster needed to have been on a</p>	F 371	<p>3. Dietary Manager will be educated by Administrator by 4/7/15 regarding storing, preparing, distributing, and serving food under sanitary conditions. Dietary Manager will educate dietary staff regarding storing, preparing, distributing, and serving food under sanitary conditions by 4/10/15. Dietary Manager will educate dietary staff regarding cleaning assignments by 4/10/15. Dietary Manager will educate dietary staff regarding reporting and monitoring of ice build-up in walk-in freezer by 4/10/15. Staff Development Coordinator will educate all staff by 4/16/15 regarding ensuring dumpster doors are closed. Dietary staff will be educated by Maintenance Director regarding reporting broken tiles and grout build up by 4/15/15.</p> <p>4. Range hood audit will be completed monthly x 3 months by Dietary Manager to ensure range hood is free from rust and build-up. Dietary Manager will monitor daily/weekly cleaning schedules 3x per week x 12 weeks to ensure schedules are being followed. Walk-in</p>		

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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 03/13/2016
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 371	<p>Continued From page 10</p> <p>solid surface. She stated the ice build up on the pipes had previously been addressed and cleaned, however, this returned frequently. She revealed the floors were on a cleaning schedule, as well as the cleaning of the convection oven and floors were to have been cleaned and mopped after meals and she was unaware of a deep cleaning done periodically on the tiles and grout.</p> <p>Review of the cleaning schedules for the kitchen and storage area, for March 2015, revealed several empty blocks where staff were to have Initialed the assignment was completed.</p> <p>Interview with the Dietary Manager, on 03/11/15 at 12:05 PM, revealed she reviewed the assignment sheets each Friday. However, she had not determined why there were empty holes on the cleaning schedule and had not interviewed staff or followed up to determine if the cleaning had been done and not Initialed.</p> <p>Interview with the Maintenance Director on 03/12/15 at 12:30 PM, revealed he had no policy on maintenance of the kitchen floors or the dumpsters and he was not aware of the need for a solid foundation under the dumpsters.</p> <p>Interview with the Director of Nursing (DON), on 03/13/15 at 2:50 PM, revealed she had never went directly to the nursing staff to remind them to keep the sliding doors on the dumpsters closed, however, she was sure they had been made aware to do this.</p> <p>Interview with the Administrator, on 03/13/15 at 3:50 PM, revealed the floors in the kitchen were some of the oldest flooring in the building and he</p>	F 371	<p>freezer's gaskets and pipes will be inspected for ice build-up weekly x 3 months by Dietary Manager. Dumpsters will be monitored by Maintenance Director 3x per week for 12 weeks to ensure door are closed and there is no noticeable debris. Maintenance Director will audit kitchen for broken tiles and build-up on grout 1x per week for 12 weeks. 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 minimum, the Administrator, Director of Nursing, Social Services Director, and Medical Director at least quarterly.</p>		

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F 371	Continued From page 11	F 371			
F 441 SS=D	<p>was aware they possibly needed replacing. He also stated he was unaware of the need for the dumpsters to have been on a solid foundation.</p> <p>483.85 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and</p>	F 441			

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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 441	<p>Continued From page 12</p> <p>transport linens so as to prevent the spread of infection.</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 proper infection control measures to maintain a safe and sanitary environment to prevent the transmission of disease and infection for one (1) of nineteen (19) sampled residents (Resident #7) and on unsampled resident (Unsampled Resident A).</p> <p>The findings include: 1. Review of the facility's policy titled, "Assisting the Resident In-Room Meals", dated April 2001, revealed employees must wash their hands before serving food to residents. Review of facility's policy titled, "Assistance with Meals", dated October 2013, revealed all employees who provide resident assistance with meals should be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling.</p> <p>Observation on 03/12/15 at 8:31 AM revealed Resident #7 was sitting in his/her Broda chair with a meal tray placed in front of him/her. Certified Nursing Assistant (CNA) #1 was observed entering Resident #7's room then proceeded to take her left hand to touch her hair and placed her hair behind her ear. CNA #1 failed to wash his/her hands and proceeded to touch Resident</p>	F 441	<p>F 441</p> <p>1. The CNA was reeducated by the DON on 3/13/15 relating to infection control, hand washing, and meal tray set up. 2. Meal pass and tray set up was observed by the DON on 3/13/15. There were no concerns identified. 3. All staff will be re-educated by the SDC by 4/15/15 regarding infection control, hand washing, and tray set up. 4. Director of Nursing will observe 3 meal tray pass/tray set up 3 x per week for 12 weeks. 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 minimum, the Administrator, Director of Nursing, Social Services Director, and Medical Director at least quarterly.</p>	4/16/15	

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F 441	Continued From page 13 #7's clothing protector and remove the plastic from two (2) cups containing a clear liquid. Additionally, CNA#1 unwrapped the eating utensils and sweetener packet and stirred Resident #7's oatmeal. Resident #7 then picked up that same spoon and began to eat his/her oatmeal. Interview with Resident #7, on 3/13/15 at 2:15 PM revealed Resident's expectation was for staff to have clean hands when serving his/her meal and would have expected staff to sanitize their hands if they had touched their hair. Review of Resident #7's quarterly Minimum Data Set (MDS) assessment, dated 02/19/15, revealed the resident's cognition was moderately impaired with a Brief Interview for Mental Status(BIMS) score to be "12" indicating the resident was interviewable. Interview with CNA #1, on 03/12/15 at 8:40 AM, revealed she should have sanitized her hands before serving Resident #7's tray and stated that she would have used hand sanitizer if she had it to do over again. CNA#1 stated she was nervous and was just not thinking at the time. CNA #1 revealed her hand sanitizer was in her pocket and that she should have used it. Interview with Director of Nursing (DON), on 03/12/15 at 8:55 AM, revealed she expected staff to follow policy and procedure and use proper sanitation when handling resident's meals.	F 441	F 490 1. Expandable foam on IC2 East wing was replaced with approved fire caulk on 3/17/15 by Maintenance Director. 10x10 hole on IC2 West wing was patched with fire caulk on 3/17/15 by Maintenance Director. Two trash barrels, wheel chairs, and chair on IC2 west wing were immediately removed under the direction of Maintenance Director on 3/12/15. The two trash barrels were placed in the shower rooms; wheel chair was placed in resident's room; chair was returned to appropriate place in lobby. Two trash barrels, linen cart, lift, and walker on IC2 East wing were immediately removed under the direction of the Maintenance Director. Two trash barrels were placed in the shower rooms; linen cart was placed in linen closet on unit; lift was returned to proper storage area on unit. Walker was identified and returned to appropriate resident room. 2. 100% audit of all hallways was completed by Maintenance Director on 3/12/15 to ensure proper storage requirements were met. 100% audit of all smoke barriers will be completed by 4/3/15.		
F 490 SS=D	483.76 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest	F 490			

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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 490	<p>Continued From page 14</p> <p>practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. During the Life Safety Code (LSC) survey, conducted 03/12-13/15, there were deficiencies cited which were cited on the previous annual survey (01/16/14) because it had not been corrected. (Refer to K-0025 and K-0072).</p> <p>The findings include:</p> <p>Interview, on 03/13/15 at 11:25 AM, with the Administrator revealed he had re-educated the Plant Operations Director on the requirements for maintaining smoke barriers and he had checked smoke barriers himself and found no concerns as per the facilities plan of correction dated 02/21/14. In addition, the Administrator stated the Quality Assurance Committee had not received any concerns related to storage.</p>	F 490	<p>3. Maintenance Director was educated by Administrator on 4/3/15 regarding acceptable materials to use for smoke barriers. All staff will be educated by Staff Development Coordinator by 4/13/15 regarding proper storage in the corridors.</p> <p>4. Smoke barriers will be audited one time per month for 3 months by Administrator to ensure proper materials are in use and no holes are present. Corridors will be audited once a week for 3 months by Administrator to ensure proper corridor storage. 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 minimum, the Administrator, Director of Nursing, Social Services Director, and Medical Director at least quarterly.</p>	4/16/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186008	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 03/13/2015
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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 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 (87) 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 Recertification Life Safety Code survey was initiated on 03/12/15 and concluded on 03/13/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has the capacity for one-hundred twenty-two (122) beds, with a census of one-hundred sixteen (116) 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 Rehabilitation 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 the right 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 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: *Log Mall* TITLE: *Administrator* (X6) DATE: *4/3/15*

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 MORGANTOWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN STREET MORGANTOWN, KY 42261	
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K 018	<p>Continued From page 2</p> <p>staff and visitors. The facility has the capacity for one-hundred twenty-two (122) beds and at the time of the survey, the census was one-hundred sixteen (116).</p> <p>The findings include:</p> <p>Observation, on 03/12/15 at 3:51 PM, with the Plant Operations Director revealed the corridor door to room #8 had a gap larger than a half (1/2) inch and would not resist the passage of smoke.</p> <p>Interview, on 03/12/15 at 3:52 PM, with the Plant Operations Director revealed he was unaware the door gap was too large.</p> <p>Observation, on 03/12/15 at 3:53 PM, with the Plant Operations Director revealed the corridor door to room #9 had a gap larger than a half (1/2) inch and would not resist the passage of smoke.</p> <p>Interview, on 03/12/15 at 3:54 PM, with the Plant Operations Director revealed he was unaware the door gap was too large.</p> <p>Observation, on 03/13/15 at 10:20 PM, with the Plant Operations Director revealed the corridor door to room #112 had a gap larger than a half (1/2) inch and would not resist the passage of smoke.</p> <p>Interview, on 03/13/15 at 10:21 AM, with the Plant Operations Director revealed he was unaware the door gap was too large.</p> <p>The census of one-hundred sixteen (116) was verified by the Administrator on 03/13/15. The findings were acknowledged by the Administrator</p>	K 018	<p>The Quality Assurance Committee will consist of at minimum, the Administrator, Director of Nursing, Social Services Director, and Medical Director at least quarterly.</p>	

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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		
(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 018	<p>Continued From page 3 and verified by the Plant Operations Director at the exit interview on 03/13/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in</p>	K 018			

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K 018	Continued From page 4 buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018	<p>K025</p> <ol style="list-style-type: none"> Expandable foam on IC2 East wing was replaced with approved fire caulk on 3/17/15 by Maintenance Director. 10x10 hole on IC2 West wing was patched with fire caulk on 3/17/15 by Maintenance Director. 100% audit of all smoke barriers will be completed by 4/3/15 by Maintenance Director. Maintenance Director will be educated by Administrator regarding NFPA 101 standard 19.3.7.3 by 4/10/15. Smoke barriers will be audited one time per month for 3 months by Administrator to ensure proper materials are in use and no holes are present. 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 minimum, the Administrator, Director of Nursing, Social Services Director, and Medical Director at least quarterly. 	4/16/15
K 026 SS=D	<p>Reference: CMS: S&C-07-18 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation 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 National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect three (3) of ten (10) smoke compartments, thirty-seven (37) residents, staff and visitors. The facility has the capacity for one-hundred twenty-two (122) beds and at the time of the survey, the census was one-hundred sixteen (116).</p> <p>The findings include:</p>	K 026		

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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 03/13/2015
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 025	<p>Continued From page 6</p> <p>Observation, on 03/12/15 at 2:27 PM, with the Plant Operations Director revealed unrated expandable foam had been used to seal penetrations around sprinkler pipes in the smoke barrier extending above the ceiling located at the cross corridor doors in the IC2 East Wing.</p> <p>Interview, on 03/12/15 at 2:28 PM, with the Plant Operations Director revealed he was aware expandable foam was not to be used to seal penetrations in smoke barriers; however he was not aware during the removal of expandable foam to correct a deficiency received during a survey on 01/16/14, any expandable foam had been missed in the smoke barrier to seal penetrations.</p> <p>Observation, on 03/12/15 at 2:32 PM, with the Plant Operations Director revealed a ten (10) inch by ten (10) inch hole in the smoke barrier wall extending above the ceiling located at the cross corridor doors in the IC2 West Wing.</p> <p>Interview, on 03/12/15 at 2:33 PM, with the Plant Operations Director revealed he was not aware of the hole in smoke barrier.</p> <p>This is a repeat deficiency from a survey conducted on 01/16/14. Refer to F-490.</p> <p>Interview, on 03/13/15 at 11:25 AM, with the Administrator revealed he had re-educated the Plant Operations Director on the requirements for maintaining smoke barriers. Further interview revealed he had checked smoke barriers himself and found no concerns as per the facilities plan of correction dated 02/21/14.</p> <p>The census of one-hundred sixteen (116) was</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	<p>Continued From page 6</p> <p>verified by the Administrator on 03/13/15. The findings were acknowledged by the Administrator and verified by the Plant Operations Director at the exit interview on 03/13/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.7.5 Openings in smoke barriers shall be protected by fire-rated glazing; by wired glass panels and steel frames; by substantial doors, such as 1 3/4-in. (4.4-cm) thick, solid-bonded wood core doors; or by construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted. Exception: Doors shall be permitted to have fixed fire window assemblies in accordance with 8.2.3.2.2.</p> <p>Reference: NFPA 101 (2000 Edition) 8.3.6.1</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 42281		
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K 025	<p>Continued From page 7</p> <p>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 penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve 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>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. <p>8.3.8.2 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:</p> <ol style="list-style-type: none"> (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			

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K 027 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors, located in a smoke barrier, would resist the passage of smoke in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of ten (10) smoke compartments, twelve (12) residents, staff and visitors. The facility has the capacity for one-hundred twenty-two (122) beds and the census was one-hundred sixteen (116) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 03/13/15 at 8:55 AM, with the Plant Operations Director revealed the cross corridor doors located in the smoke barrier at IC1 and the Dining Room did not close completely when tested due to the door rubbing the door frame.</p>	K 027	<p>K027</p> <ol style="list-style-type: none"> 1. Cross-corridor doors located in the smoke barrier at IC1 and the Dining Room were repaired by Maintenance Director on 3/12/15 to ensure doors close completely and properly. 2. Cross-corridor doors located in the smoke barrier at IC1 and the Dining room were repaired by Maintenance Director on 3/12/15. 100% audit of all facility cross-corridor doors was completed by Maintenance Director on 3/12/15 with no other issues identified. 3. Maintenance Director will be educated by Administrator by 4/10/15 regarding NFPA standard 101 19.3.7.6 and NFPA 80 2-4.1. 4. Maintenance Director will audit all facility cross-corridor doors weekly x 3 months to ensure proper functioning. 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 minimum, the Administrator, Director of Nursing, Social Services Director, and Medical Director at least quarterly. 	4/16/15

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K 027	Continued From page 9 Interview, on 03/13/15 at 8:58 AM, with the Plant Operations Director revealed he was not aware the door was not closing completely. The census of one-hundred sixteen (116) was verified by the Administrator on 03/13/15. The findings were acknowledged by the Administrator and verified by the Plant Operations Director at the exit interview on 03/13/15. Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. Actual NFPA Standard: Reference: NFPA 101 (2000 edition), 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke. Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029		

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K 029	Continued From page 10 fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of ten (10) smoke compartments, ten (10) residents, staff and visitors. The facility has the capacity for one-hundred twenty-two (122) beds and at the time of the survey, the census was one-hundred sixteen (116). The findings include: 1. Observation, on 03/12/15 at 4:16 PM, with the Plant Operations Director revealed a hazardous amount of paper storage in the Assistant Director of Nursing Office located in 1C2. The door was not equipped with a self-closing device to keep the door closed. Interview, on 03/12/15 at 4:16 PM, with the Plant Operations Director revealed he was not aware	K 029	K029 1. A self-closing device was installed on door to ADON office and door to Boiler room on 3/21/15 by Maintenance Director. 100% audit of all facility storage area doors was completed by Maintenance Director on 3/13/15 with no other issues identified. 2. A self-closing device was installed on door to ADON office and door to Boiler room on 3/21/15 by Maintenance Director. 2. Maintenance Director will be educated by Administrator by 4/10/15 regarding NFPA standards 101 9.3.2.1 & 7.2.1.8 & 7.2.1.8.2. 4. All storage/hazardous area doors requiring will be audited monthly x 3 months by Maintenance Director to ensure acceptable self-closing standards are met. 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 minimum, the Administrator, Director of Nursing, Social Services Director, and Medical Director at least quarterly.	4/16/15

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K 029	<p>Continued From page 11</p> <p>the room would have to meet the requirements of protection from hazards.</p> <p>2. Observation, on 03/13/15 at 10:28 AM, with the Plant Operations Director revealed the Boiler Room located in the Basement was not equipped with a self-closing device to keep the door closed.</p> <p>Interview, on 03/13/15 at 10:29 AM, with the Plant Operations Director revealed he was not aware the room did not meet the requirements of protection from hazards.</p> <p>The census of one-hundred sixteen (116) was verified by the Administrator on 03/13/15. The findings were acknowledged by the Administrator and verified by the Plant Operations Director at the exit interview on 03/13/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.2 Protection from Hazards.</p> <p>Reference: NFPA 101 (2000 Edition) 9.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p>	K 029		

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K 029	<p>Continued From page 12</p> <p>(1) Boiler and fuel-fired heater rooms ;</p> <p>(2) Central/bulk laundries larger than 100 ft² (9.3 m²)</p> <p>(3) Paint shops</p> <p>(4) Repair shops</p> <p>(5) Soiled linen rooms</p> <p>(6) Trash collection rooms</p> <p>(7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction</p> <p>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing,</p>	K 029		

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K 029	Continued From page 13 provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 029		
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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the path of egress was maintained free from obstructions or impediments to allow for full instant use for fire or	K 038	K038 1. Exit door in Dining Room and exit door in Secure unit	4/16/15

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K 038	<p>Continued From page 14</p> <p>other emergencies in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect four (4) of ten (10) smoke compartments, twenty-six (26) residents, staff and visitors. The facility has the capacity for one-hundred twenty-two (122) beds and at the time of the survey, the census was one-hundred sixteen (116).</p> <p>The findings include:</p> <p>Observation, on 03/12/15 at 4:24 PM, with the Plant Operations Director revealed the exit door located in the Dining Room failed to open with the keypad. The door was not equipped with delayed egress.</p> <p>Interview, on 03/12/15 at 4:25 PM with the Plant Operations Director revealed he was not aware of the requirements for locks located in the path of egress.</p> <p>Observation, on 03/13/15 at 9:27 AM, with the Plant Operations Director revealed the exit door located in the Secured Unit failed to open with the keypad. The door was not equipped with delayed egress.</p> <p>Interview, on 03/13/15 at 9:28 AM with the Plant Operations Director revealed he was not aware of the requirements for locks located in the path of egress.</p> <p>Observation, on 03/13/15 at 10:04 AM, with the Plant Operations Director revealed the path of egress from the IC1 Bend Hall had two (2) delays in the path of egress. The first delay was located at the door to enter the stairwell which led down</p>	K 038	<p>were repaired on 3/31/15 by contracted vendor to function with replaced keypads.</p> <p>2.100% audit of all other doors was completed by Maintenance Director on 3/13/15 with no other concerns identified. Exit door in Dining Room and exit door in Secure unit were repaired on 3/31/15 by contracted vendor to function with replaced keypads. An alarm for basement exit door across from stairwell will be installed by Maintenance Director by 4/20/15.</p> <p>3. Maintenance Director will be educated by Administrator by 4/10/15 regarding NFPA 101 19.2.10 & NFPA 101 7.10 & 7.2.1.6.1 & 7.2.1.5.</p> <p>4. All exterior doors will be audited 2 x per month x 3 months by Maintenance Director to ensure all doors are operating appropriated with corresponding keypads. 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 minimum, the Administrator, Director of Nursing, Social Services Director, and Medical Director at least quarterly.</p>	

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K 038	<p>Continued From page 15</p> <p>one (1) floor to the Basement. The stairwell opened to the Basement Corridor with the exit located across the hall from the stairwell, which also had a keypad lock.</p> <p>Interview, on 03/13/15 at 10:05 AM with the Plant Operations Director revealed he was not aware of the requirements for locks located in the path of egress.</p> <p>The census of one-hundred sixteen (116) was verified by the Administrator on 03/13/15. The findings were acknowledged by the Administrator and verified by the Plant Operations Director at the exit interview on 03/13/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10. Exception: Where the path of egress travel is obvious, signs shall not be required in one-story buildings with an occupant load of fewer than 30 persons.</p> <p>Reference: NFPA 101 (2000 Edition) 7.10 MARKING OF MEANS OF EGRESS 7.10.1 General. 7.10.1.1 Where Required. Means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 42. 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits,</p>	K 038			

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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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2016
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	Continued From page 16 shall be marked by an approved sign readily visible from any direction of exit access. 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. Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling	K 038		

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K 038	<p>Continued From page 17 the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Exception No. 1: This requirement shall not apply</p>	K 038		

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K 038	Continued From page 18 where otherwise provided in Chapters 18 through 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy. (b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED (c) The locking device is of a type that is readily distinguishable as locked. (d) A key is immediately available to any occupant inside the building when it is locked. Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause. Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which egress is to be made.	K 038		
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain emergency lighting in accordance with the	K 048	K046 1. New emergency light in Generator / Transfer Switch room was installed by Maintenance Director on 3/26/15.	4/16/15

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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 046	<p>Continued From page 19</p> <p>National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect ten (10) of ten (10) smoke compartments, one-hundred twenty-two (122) residents, staff and visitors. The facility has the capacity for one-hundred twenty-two (122) beds and at the time of the survey, the census was one-hundred sixteen (116).</p> <p>The findings include:</p> <p>Observation, on 03/13/15 at 10:26 AM, with the Plant Operations Director revealed the battery powered emergency light located in the Generator/Transfer Switch Room failed to illuminate when tested.</p> <p>Interview, on 03/13/15 at 10:27 AM, with the Plant Operations Director revealed he was not aware the battery powered emergency light located in the Generator/Transfer Switch Room had stopped working.</p> <p>The census of one-hundred sixteen (116) was verified by the Administrator on 03/13/15. The survey findings were acknowledged by the Administrator and verified by the Plant Operations Director at the exit interview on 03/13/15.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at</p>	K 046	<p>2. 100% audit of all facility emergency lights was completed by Maintenance Director on 3/13/15 with no issues identified.</p> <p>New emergency light in Generator / Transfer Switch room was installed by Maintenance Director on 3/26/15.</p> <p>3. Maintenance Director will be educated by Administrator by 4/10/15 regarding NFPA standard 101 7.9.2.1 & 7.9.3.</p> <p>4. Maintenance Director will audit all emergency lights function 2x per month x 3 months. 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 minimum, the Administrator, Director of Nursing, Social Services Director, and Medical Director at least quarterly.</p>	

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K 046	Continued From page 20 floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046			
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.8.1.4	K 052			

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K 052	<p>Continued From page 21</p> <p>This STANDARD is not met as evidenced by: Based on observation during the testing of the fire alarm and interview, it was determined the facility failed to ensure the fire alarm system was inspected and tested in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice has the potential to affect one (1) of ten (10) smoke compartments, twelve (12) residents, staff and visitors. The facility has the capacity for one-hundred twenty-two (122) beds and at the time of the survey, the census was one-hundred sixteen (116).</p> <p>The findings include:</p> <p>Observation during the testing of the fire alarm, on 03/13/15 at 11:00 AM, with the Plant Operations Director revealed the magnetic lock on the Basement Exit Door to the Smoking Area failed to release upon activation of the Fire Alarm.</p> <p>Interview, on 03/13/15 at 11:01 AM, with the Plant Operations Director revealed he was unaware the magnetic lock did not release with the activation of the fire alarm control panel.</p> <p>The census of one-hundred sixteen (116) was verified by the Administrator on 03/13/15. The</p>	K 052	<p>K052</p> <p>1. Basement exit door to smoking area was restored to proper function on 3/16/15 by contracted vendor. 2. 100% audit of all other facility exit doors was completed by Maintenance Director on 3/13/15 with no other issues identified. Basement exit door to smoking area was restored to proper function on 3/16/15 by contracted vendor.</p> <p>3. Maintenance Director will be educated by Administrator by 4/10/15 regarding NFPA standard 101 9.6.1.4.</p> <p>4. Maintenance Director will audit basement exit door to smoking area weekly x 12 weeks to ensure magnetic lock is released with fire alarm. 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 minimum, the Administrator, Director of Nursing, Social Services Director, and Medical Director at least quarterly.</p>	4/16/15

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K 052	Continued From page 22 findings were acknowledged by the Administrator and verified by the Plant Operations Director at the exit interview on 03/13/15. Actual NFPA Standard: NFPA 101 (2000 Edition), 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.	K 052			
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide electronic supervision (tamper switches) for a water supply control valve installed on the sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect ten (10) of ten (10) smoke compartments, one-hundred twenty-two (122) residents, staff and visitors. The facility has the capacity for one-hundred twenty-two (122) beds and at the time of the survey, the census was one-hundred sixteen (116).	K 061			

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K 061	<p>Continued From page 23</p> <p>The findings include:</p> <p>Observation, on 03/13/15 at 10:38 AM, with the Plant Operations Director revealed the Post Indicator Valve (PIV) for the Sprinkler System was not electronically connected to the Fire Alarm. The valve had a lock on the handle but was not electronically supervised.</p> <p>Interview on 03/13/15 at 10:39 AM, with the Plant Operations Director revealed he was not aware that electronic supervision of the PIV was required.</p> <p>The census of one-hundred sixteen (116) was verified by the Administrator on 03/13/15. The findings were acknowledged by the Administrator and verified by the Plant Operations Director at the exit interview on 03/13/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.5 Extinguishment Requirements. 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. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered. 19.3.5.2*</p>	K 061	<p>K061</p> <ol style="list-style-type: none"> 1. Professional vendor was contacted on 4/13/15 to install electronic supervision to post indicator valve for the sprinkler system. 2. Professional vendor was contacted on 4/13/15 to install electronic supervision to post indicator valve for the sprinkler system. 3. Maintenance Director will be educated by Administrator by 4/10/15 regarding NFPA standard 101 19.3.5 & 9.7.2.1 & 19.3.5.1. 4. Maintenance Director will audit electronic supervision system monthly x 3 months to ensure proper function. 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 minimum, the Administrator, Director of Nursing, Social Services Director, and Medical Director at least quarterly. 	4/26/15

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K 081	Continued From page 24 Where this Code permits exceptions for fully sprinklered buildings or smoke compartments, the sprinkler system shall meet the following criteria: (1) It shall be in accordance with Section 9.7. (2) It shall be electrically connected to the fire alarm system. (3) It shall be fully supervised. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered. Reference: NFPA 101 (2000 Edition) 9.7.2.1*. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.	K 061			
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 25</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 National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of ten (10) smoke compartments, twenty-five (25) residents, staff and visitors. The facility has the capacity for one-hundred twenty-two (122) beds and at the time of the survey, the census was one-hundred sixteen (116).</p> <p>The findings include:</p> <p>1. Observation, on 03/12/15 at 3:35 PM, with the Plant Operations Director revealed the storage of two (2) trash cans, a chair, and a wheelchair located in the IC2 West Wing Hall.</p> <p>Interview, on 03/12/15 at 3:36 PM, with the Plant Operations Director revealed the items were routinely stored in this location.</p> <p>2. Observation, on 03/12/15 at 3:42 PM, with the Plant Operations Director revealed the storage of two (2) trash cans, a linen cart, a lift, and a walker located in the IC2 East Wing Hall.</p> <p>Interview, on 03/12/15 at 3:43 PM, with the Plant Operations Director revealed the items were</p>	K 072	<p>K072</p> <p>1. Two trash barrels, wheel chairs, and chair on IC2 west wing were immediately removed under the direction of Maintenance Director on 3/12/15. The two trash barrels were placed in the shower rooms; wheel chair was placed in resident's room; chair was returned to appropriate place in lobby. Two trash barrels, linen cart, lift, and walker on IC2 East wing were immediately removed under the direction of the Maintenance Director. Two trash barrels were placed in the shower rooms; linen cart was placed in linen closet on unit; lift was returned to proper storage area on unit. Walker was identified and returned to appropriate resident room.</p>	

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K 072	Continued From page 26 routinely stored in this location. This is a repeat deficiency from a survey conducted on 01/16/14. Refer to F-490. Interview, on 03/13/15 at 11:12 AM, with the Administrator revealed he was not aware the items were being stored in the corridors. Further interview revealed the Quality Assurance Committee had not received any concerns regarding storage in the corridors. The census of one-hundred sixteen (116) was verified by the Administrator on 03/13/15. The findings were acknowledged by the Administrator and verified by the Plant Operations Director at the exit interview on 03/13/15. Actual NFPA Standard: 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. Reference: NFPA 101 (200 Edition) 7.3.2* Measurement of Means of Egress. The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration. Exception: Projections not more than 31/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below. Reference: S&C-12-21-LSC NFPA 101 LIFE SAFETY CODE STANDARD	K 072	2. 100% audit of all hallways was completed by Maintenance Director on 3/12/15 to ensure proper storage requirements were met. 3. All staff will be educated by Staff Development Coordinator by 4/13/15 regarding proper storage in the corridors. 4. Corridors will be audited once a week for 3 months by Administrator to ensure proper corridor storage. 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 minimum, the Administrator, Director of Nursing, Social Services Director, and Medical Director at least quarterly.	4/16/15
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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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(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 075 SS=D	<p>Continued From page 27</p> <p>Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure linen or trash collection receptacles with capacities greater than thirty-two (32) gallons were stored in accordance with National Fire Protection Association (NFPA) standards. The deficient practice had the potential to affect two (2) of ten (10) smoke compartments, twenty-five (25) residents, staff and visitors. The facility has the capacity for one-hundred twenty-two (122) beds and at the time of the survey, the census was one-hundred sixteen (116).</p> <p>The findings include:</p> <p>Observation, on 03/12/15 at 3:35 PM, with the Plant Operations Director revealed two (2) linen containers with a capacity of over thirty two (32) gallons were being stored in the IC2 East Wing Hall.</p>	K 075	<p>K075</p> <ol style="list-style-type: none"> 37 gallon trash collection receptacles were immediately returned to shower room on unit under the direction of the Maintenance Director on 3/12/15. 100% of all floors of facility revealed additional 37 gallon receptacles being in use. All 37 gallon receptacles were returned to the shower room on the unit. New trash collection receptacles were ordered by Administrator on 4/13/15. The facility will ensure no receptacles over 32 gallon are in use on hallways and all 37 gallon receptacles will be replaced upon arrival of ordered receptacles. Maintenance Director will be educated by Administrator by 4/10/15 regarding NFPA standard 101 19.7.6.5. All staff will be educated by Administrator by 4/15/15 regarding NFPA standard 101 19.7.6.5. 	4/16/15

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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 03/13/2015
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 075	<p>Continued From page 28</p> <p>Interview, on 03/12/15 at 3:36 PM, with the Plant Operations Director revealed he was not aware of the requirement for linen and trash receptacles with capacities greater than thirty two (32) gallons.</p> <p>Observation, on 03/12/15 at 3:42 PM, with the Plant Operations Director revealed two (2) linen containers with a capacity of over thirty two (32) gallons were being stored in the IC2 West Wing Hall.</p> <p>Interview, on 03/12/15 at 3:43 PM, with the Plant Operations Director revealed he was not aware of the requirement for linen and trash receptacles with capacities greater than thirty two (32) gallons.</p> <p>The census of one-hundred sixteen (116) was verified by the Administrator on 03/13/15. The findings were acknowledged by the Administrator and verified by the Plant Operations Director at the exit interview on 03/13/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.7.5.5 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft² (20.4 L/m²). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft² (5.9-m²) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended.</p> <p>Exception: Container size and density shall not</p>	K 075	<p>4. Administrator will audit all facility wings weekly x 12 weeks to ensure no trash collection receptacles over 32 gallons are in use. 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 minimum, the Administrator, Director of Nursing, Social Services Director, and Medical Director at least quarterly.</p>	

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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 03/13/2015
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 075 K 144 SS=F	Continued From page 29 be limited in hazardous areas. NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect ten (10) of ten (10) smoke compartments, one-hundred twenty-two (122) residents, staff and visitors. The facility has the capacity for one-hundred twenty-two (122) beds and on the day of the survey the census was one-hundred sixteen (116). The findings include: Observation, on 03/13/15 at 10:26 AM, with the Plant Operations Director revealed the Generator and Transfer Switch were located in the Basement Boiler Room and did not have a two (2) hour separation from boilers and other combustible storage.	K 075 K 144	K144 1. Contracted vendor and company representative was	4/26/15	

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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 03/13/2015
NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN STREET MORGANTOWN, KY 42281	
(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 144	<p>Continued From page 30</p> <p>Interview, on 03/13/15 at 10:27 AM, with the Plant Operations Director revealed he was not aware of the requirement.</p> <p>The census of one-hundred sixteen (116) was verified by the Administrator on 03/13/15. The findings were acknowledged by the Administrator and verified by the Plant Operations Director at the exit interview on 03/13/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 7.9.2.3 Emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Stored electrical energy systems, where required in this Code, shall be installed and tested in accordance with NFPA 111, Standard on Stored Electrical Energy Emergency and Standby Power Systems.</p> <p>Reference: NFPA 110 (1999 Edition) 5-2.1 The EPS shall be installed in a separate room for Level 1 installations. EPSS equipment shall be permitted to be installed in this room. The room shall have a minimum 2-hour fire rating or shall be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. No other equipment, including architectural appurtenances,</p>	K 144	<p>contacted regarding receiving a new generator and placing it at a different location than current generator on 4/6/15.</p> <p>2. New generator will be installed in a location with a 2 hour separation from combustible storage upon arrival.</p> <p>3. Maintenance Director will be educated by the Administrator by 4/15/15 regarding NFPA 110 standard 5-2.1</p> <p>4. Any issues regarding new generator 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 minimum, the Administrator, Director of Nursing, Social Services Director, and Medical Director at least quarterly.</p>	

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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 03/13/2015
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 144	Continued From page 31 except those that serve this space, shall be permitted in this room.	K 144	K147 1. Oxygen concentrator was immediately unplugged from power strip and plugged in to appropriate receptacle. Power strips in rooms 10,3,102 were immediately removed by Maintenance Director. Extension cord in Secure Unit was immediately removed and disposed of by Maintenance Director on 3/13/15. 2. 100% audit of all resident rooms was completed by Maintenance Director on 3/13/15 to ensure no extension cords or power strips were in use. Oxygen concentrator was immediately unplugged from power strip and plugged in to appropriate receptacle. Power strips in rooms 10,3,102 were immediately removed by	4/16/15
K 147 SS=E	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 deficiency had the potential to affect three (3) of ten (10) smoke compartments, twenty-seven (27) residents, staff and visitors. The facility has the capacity for one-hundred twenty-two (122) beds and at the time of the survey, the census was one-hundred sixteen (116). The findings include: 1. Observation, on 03/12/15 at 3:39 PM, with the Plant Operations Director revealed an oxygen concentrator was plugged into a power strip (UL 56CF) located in the Main Lobby. Interview, on 03/12/15 at 3:40 PM, with the Plant Operations Director revealed he was not aware of the requirements for the proper use of power strips. 2. Observation, on 03/12/15 at 3:50 PM, with	K 147		

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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	
(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 147	<p>Continued From page 32</p> <p>the Plant Operations Director revealed a power strip (UL 3075048) was in use for personal electronics located under the bed in Resident Room #10.</p> <p>Interview, on 03/12/15 at 3:51 PM, with the Plant Operations Director revealed he was not aware of the requirements for the proper use of power strips.</p> <p>3. Observation, on 03/12/15 at 4:20 PM, with the Plant Operations Director revealed a power cord to a copy machine was run through a doorway located in the South Hall Copy Room.</p> <p>Interview, on 03/12/15 at 4:21 PM, with the Plant Operations Director revealed he was not aware of the requirement for cords running through doorways.</p> <p>4. Observation, on 03/12/15 at 4:22 PM, with the Plant Operations Director revealed a power strip (UL 3075048) was in use for personal electronics located under the bed in Resident Room #3.</p> <p>Interview, on 03/12/15 at 4:23 PM, with the Plant Operations Director revealed he was not aware of the requirements for the proper use of power strips.</p> <p>5. Observation, on 03/13/15 at 9:25 AM, with the Plant Operations Director revealed an extension cord to a television located in the Secured Unit Dining Room.</p> <p>Interview, on 03/13/15 at 9:26 AM, with the Plant Operations Director revealed he was aware of the requirements for extension cords; however, was</p>	K 147	<p>Maintenance Director.</p> <p>Extension cord in Secure Unit was immediately removed and disposed of by Maintenance Director on 3/13/15. Electrical outlet will be installed in the copy room by Maintenance Director, eliminating the need for cords to be ran through the doorway by 4/15/15.</p> <p>3. Maintenance Director will be educated by Administrator regarding NFPA 101 9.1.2 & NFPA 70 400-8 & NFPA 99 3-3.2.1.2 (D)</p> <p>4. 100% audit of all resident care areas will be completed 2x per month x 3 months by Maintenance Director to ensure no power strips or extension cords are in use. 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 minimum, the Administrator, Director of Nursing, Social Services Director, and Medical Director at least quarterly.</p>	

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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 147	<p>Continued From page 33 not aware the extension cord was in use.</p> <p>6. Observation, on 03/13/15 at 9:59 AM, with the Plant Operations Director revealed a power strip was in use one (1) foot from the bed in Resident Room #102.</p> <p>Interview, on 03/13/15 at 10:00 AM, with the Plant Operations Director revealed he was not aware of the requirements for the proper use of power strips.</p> <p>The census of one-hundred sixteen (116) was verified by the Administrator on 03/13/15. The findings were acknowledged by the Administrator and verified by the Plant Operations Director at the exit interview on 03/13/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 (1999 Edition) 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural</p>	K 147			

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NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN 8 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 147	<p>Continued From page 34</p> <p>ceilings, suspended ceilings, dropped ceilings, or floors</p> <p>(3) Where run through doorways, windows, or similar openings</p> <p>(4) Where attached to building surfaces</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 (D) Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference: CMS S&C 14-46-LSC</p>	K 147		