

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

PRINTED: 12/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185329	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/01/2015
NAME OF PROVIDER OR SUPPLIER MORGANFIELD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH CARRIER ST. MORGANFIELD, KY 42437		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Based upon implementation of the acceptable PoC, the facility was deemed to be in compliance 11/23/15, as alleged.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185329	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 12/1/2015
Name of Facility MORGANFIELD NURSING & REHABILITATION CENTER		Street Address, City, State, Zip Code 509 NORTH CARRIER ST. MORGANFIELD, KY 42437

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0155</u> Reg. # <u>483.10(b)(4)</u> LSC _____	Correction Completed 11/23/2015	ID Prefix <u>F0281</u> Reg. # <u>483.20(k)(3)(I)</u> LSC _____	Correction Completed 11/23/2015	ID Prefix <u>F0309</u> Reg. # <u>483.25</u> LSC _____	Correction Completed 11/23/2015
ID Prefix <u>F0333</u> Reg. # <u>483.25(m)(2)</u> LSC _____	Correction Completed 11/23/2015	ID Prefix <u>F0371</u> Reg. # <u>483.35(l)</u> LSC _____	Correction Completed 11/23/2015	ID Prefix <u>F0514</u> Reg. # <u>483.75(l)(1)</u> LSC _____	Correction Completed 11/23/2015
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____	Reviewed By <u>OH</u>	Date: <u>12/01/15</u>	Signature of Surveyor: <u>Deborah C. [Signature]</u>	Date: <u>12/01/15</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 10/9/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		

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NAME OF PROVIDER OR SUPPLIER MORGANFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH CARRIER ST. MORGANFIELD, KY 42437
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F 000	INITIAL COMMENTS A Recertification Survey was conducted on 10/06/15 through 10/09/15 with deficient practice identified at the highest Scope and Severity of an "E".	F 000	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in the response of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegations by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within the (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this time frame should in no way be construed or considered as an agreement with the allegations of noncompliance or	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure advance directives were implemented for one (1) resident, in the	F 155		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Wood TITLE: Administrator (X6) DATE: 11/30/15

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 155	<p>Continued From page 1</p> <p>selected sample of fifteen (15) residents (Resident #14). The facility admitted Resident #14 with advance directives which revealed a desire to be provided cardiopulmonary resuscitation (CPR). The resident was found unresponsive on 09/21/15 and the facility staff failed to implement CPR in accordance with the facility's policy/procedure. Additionally, during routine personnel record reviews, it was determined one hundred percent (100%) of the licensed staff in the facility were not current in CPR certification.</p> <p>The findings include:</p> <p>Review of the facility's policy/procedure, "Cardiopulmonary Resuscitation (CPR)", dated 02/17/15, revealed it is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement guidelines regarding cardiopulmonary resuscitation. Review of the guidelines revealed the following</p> <ol style="list-style-type: none"> 1. The facility will follow current American Heart Association (AHA) guidelines regarding CPR. 2. If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and: <ol style="list-style-type: none"> a. In accordance with the resident's advance directives, or b. In the absence of advance directives or a Do Not Resuscitate order; and c. If the resident does not show obvious signs of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition). 3. CPR certified staff will be available at all times. 	F 155	<p>admission by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p> <p>F 155 RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>1) The resident identified as resident # 14 expired on 9/21/15 at the facility.</p> <p>2) A review of all current residents' advanced directives were reviewed by the Director of Nursing on October 8, 2015 to determine if all current resident's code status was identified and a physician's order present if the advanced directive was for a "Do Not Resuscitate". There were no concerns identified. In addition a comprehensive care plan was initiated for all current residents regarding code status. This was completed by Social Service Director on October 9, 2015. On 10/26/15 the Director of Nursing completed an audit on all current residents for code status and care plan. No issues found. All new</p>		

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F 155	<p>Continued From page 2</p> <p>4. Staff will maintain current CPR certification for healthcare providers through a CPR provider who evaluates proper technique through in-person demonstration of skills. CPR certification which includes an online knowledge component, yet still requires in-person skills demonstrations to obtain certification or recertification, is also acceptable.</p> <p>The facility admitted Resident #14 on 08/01/15 with diagnoses to include Colon Cancer, Abdominal Pain, and Chronic Airway Obstruction. Review of the Advanced Directives were signed by the resident's Power of Attorney (POA) on 08/01/15, indicating the desire for the resident to be provided CPR in the event the resident's breathing and/or heart function has ceased. The CPR section was checked and revealed "I am expressing a desire to have Cardiopulmonary Resuscitation to be done in the event of cardiac arrest. I understand that in the event of an observed or unobserved cardiac arrest, CPR will be initiated by staff and emergency personnel will be called".</p> <p>Review of a Nurse's Note, dated 09/21/15 at 4:47 PM, revealed documentation by Registered Nurse (RN) #2 to "see discharge disposition".</p> <p>Review of the Discharge Disposition form, dated 09/21/15 at 2:00 PM, revealed documentation by RN #2 which stated, "Resident expired at approximately 2:00 PM. No vital signs present. Verified by two (2) RNs. Chest compressions were given until rust colored contents expelled from his/her mouth, and the resident's spouse was in the room crying, saying stop I want to see my husband".</p> <p>Review of the Provisional Report of Death, dated</p>	F 155	<p>admits will be reviewed and care plan will be initiated upon admission by SSD and will be reviewed quarterly and as needed with any change in condition by Interdisciplinary Team to ensure that they are consistent with the resident's documented choices and goals. The Interdisciplinary Team will consist of at least DON, MDS, and SSD.</p> <p>3) The facility has implemented the following system: On admission the code status of the resident will be reviewed with the resident and or their responsible party to determine desired code status. At that time the appropriate paperwork will be completed if the resident or their responsible party wished to be a Do Not Resuscitate. A care plan will be initiated and the physician contacted if there is a need for a Do Not Resuscitate order. The Admission team consisting of the Social Services Director and Business Office Manager were educated on this process by the Administrator and a competency test completed on October 8, 2015. On October 8, 2015 the</p>		

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F 155	<p>Continued From page 3</p> <p>09/21/15 at 2:00 PM, revealed the signature of the POA indicating authorization was granted to release the remains to the funeral home.</p> <p>Interview with RN #2, on 10/08/15 at 3:20 PM, revealed, on 09/21/15, she was summoned to Resident #14's room. RN #2 revealed she observed the resident in the bathroom, sitting upright on the commode with his/her face, arms, and legs "blotchy" in color and skin cool to touch. The resident was moved to his/her bed and his/her legs were hard to straighten out and lay flat. RN #2 could not recall how she knew the resident was a full code, but "just knew" and started chest compressions. She revealed she stopped compressions when "stuff" came out of the resident's mouth. RN #2 stated she was unsure when not to initiate CPR, when a resident was a full code. She stated the facility had a procedure, but she would have to review it to know when not to initiate CPR, when CPR can be stopped, or if she was supposed to call 911. RN #2 revealed she was not current in CPR certification.</p> <p>Interview with RN #1, on 10/08/15 at 4:25 PM, revealed, on 09/21/15, a Certified Nurse Aide (CNA) ran out of Resident #14's room saying a nurse was needed immediately. RN #1 entered Resident #14's room and observed the resident in the bathroom on the commode unresponsive, grey in color, and skin cool to touch. No pulse was present and there was no chest rise indicating breathing. The resident was moved to the bed and RN #2 started chest compressions, but RN #1 did not initiate any breaths. They stopped CPR because Resident #14's spouse was behind the privacy curtain, stating to stop CPR, he/she was gone. RN #1 stated the spouse</p>	F 155	<p>Administrator re-educated the Interdisciplinary team consisting the Director of Nursing, MDS Nurse, Social Services Director, Activity Director, Dietary Services Manager, on the requirement to develop plan of care to meet the resident's needs to include medical condition, psychosocial needs, diagnosis and medications. On October 8, 2015, the Regional Quality Manager educated the Director of Nursing on the requirement of a nurse to immediately begin CPR if the resident has designated to have CPR initiated per the 2010 American Heart Association healthcare setting guidelines for CPR. The Director of Nursing will educate all licensed staff on the requirement of a nurse to immediately begin CPR if the resident has designated to have CPR initiated per the 2010 American Heart Association healthcare setting guidelines for CPR. All licensed staff were certified by AHA on 10/9/15. On October 8 and October 9, 2015 the Human Resources Manager</p>		

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F 155	<p>Continued From page 4</p> <p>was not the resident's POA. RN #1 revealed no one asked for the crash cart, and did not know what was on the crash cart, and was unsure if 911 was called. She stated if she had known the resident was a full code, she would not have stopped.</p> <p>Interview with CNA #2, on 10/09/15 at 8:50 AM, revealed, on 09/21/15, she was obtaining residents' weights and when she knocked on Resident #14's room, his/her spouse stated he/she was looking for Resident #14. CNA #2 stated she looked in the bathroom and saw Resident #14 leaned back, sitting on the commode with his/her mouth open, so CNA #2 ran to a hall phone and paged for a nurse to come to his/her room. RN #1 came to the room and CNA #2 took Resident #14's spouse to the other side of the room behind the privacy curtain in an attempt to console him/her. CNA #2 revealed a code was not called and she did not hear or see any activity that was like a code. She revealed Resident #14's spouse did not tell the staff who were with Resident #14 to stop CPR, and had only requested to see Resident #14.</p> <p>Interview with CNA #3, on 10/09/15 at 9:35 AM, revealed she was assigned to Resident #14 on 09/21/15 but did not find the resident in the bathroom. CNA #3 revealed she assisted in moving Resident #14 back to the bed. She stated the resident's skin was white, and no one initiated a code or did CPR. She did not recall anyone discussing a code status. CNA #3 revealed she last saw Resident #14 about 1:00 PM and stated he/she did not need anything at that time.</p> <p>Interview with RN #3, on 10/09/15 at 10:40 AM, revealed when she arrived to Resident #14's</p>	F 155	<p>audited personnel records of all licensed staff to determine if their CPR status was current. A file will be maintained by HR to ensure CPR certification is current at all times for licensed staff. Weekly audits of all licensed staff will be preformed by HR and reminder will be sent to the licensed nurse by HR 60 days prior to the expiration of the CPR certification. All staff will be offered the CPR certification class. Audit on 10/12/15 by Director of Nursing on current/active nurses to validate CPR certification and no issues found.</p> <p>4) Monitoring of the plan of correction will be performed by the following: The Director of Nursing or Assistant Director of Nursing will audit all admissions weekly to assure that code status has been identified and a care plan initiated. The DON will conduct mock code drills weekly one each shift for four (4) weeks followed by weekly drills for eight (8) weeks. All monitoring will be reviewed monthly for (3) months by the Quality Assurance</p>		

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F 155	Continued From page 5 room, he/she was already on the bed and was "stiff and white" and staff were performing post mortem care. Someone asked her to phone the resident's physician and daughter. She notified the physician and reported the resident had expired. RN #3 was unaware if 911 was called and did not discuss the code status of Resident #14 with anyone. Interview with the Director of Nursing (DON), on 10/08/15 at 2:45 PM, revealed, on 09/21/15, she was out of the facility and when she returned, she was notified Resident #14 was deceased. She stated staff initiated CPR and his/her spouse requested the staff stop CPR; however, there was no documentation to verify this information. She revealed she looked into it and RN #2 performed chest compressions and stopped when the spouse requested, but she would have expected RN #2 to continue CPR. Additionally, she revealed if a resident was determined to be Full Code status, it should be in the resident's record. She stated staff were to call a Code, get the crash cart, initiate CPR, call 911, and continue until EMS arrived, or until the physician or the POA said to stop CPR. Additional interview with the DON, on 10/09/15 at 11:40 AM, revealed the facility was responsible to ensure staff keep his or her CPR certification current. A previous employee was contracted to provide CPR recertification when the facility staff required it. She was unable to provide verification that one hundred percent (100%) of the licensed staff were current in CPR certification.	F 155	Committee for further recommendations if needed until substantial compliance is achieved. If at any time concerns are identified, a Quality Assurance Committee meeting will be convened to make further recommendations. The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, the Assistant Director of Nursing, the MDS nurse, Social Services Director and Medical Director attending at least quarterly. Failure to comply with any of the above will result in individual re-training and as appropriate, disciplinary action. 5) Completion date is 11/22/15		
F 281 SS=D	483.20(k)(3)(I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	F 281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS 1) The resident identified as resident # 14 expired at facility on 9/21/15. Registered Nurse (RN #1) was re-educated by the Director of Nursing on October 7, 2015 to the professional	11/23/15	

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F 281	<p>Continued From page 6</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</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 the services provided by the facility meet professional standards for two (2) residents, in the selected sample of fifteen (15) residents (Residents #11 and #14). Resident #11 was administered a medication that was inappropriately crushed during a medication pass on 10/07/15. Resident #14, who had Advanced Directives, which indicated the desire to be provided Cardiopulmonary Resuscitation (CPR), experienced a cardiac event and the staff failed to provide CPR as per the facility's policy.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's policy/procedure, "Cardiopulmonary Resuscitation (CPR)", dated 02/17/15, revealed it is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement guidelines regarding cardiopulmonary resuscitation. Review of the guidelines revealed the following <ol style="list-style-type: none"> 1. The facility will follow current American Heart Association (AHA) guidelines regarding CPR. 2. If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and: <ol style="list-style-type: none"> a. In accordance with the resident's advance directives, or 	F 281	<p>standard of quality related to the Facility's Medication Administration policy/procedure to refer to the "Medications Not To Be Crushed List" and review the medication card to reveal a "do not crush" label on the card.</p> <p>2) On 10/7/15, the MD for resident #11 gave a verbal order to change medication to a crushable medication. Resident #11 did not experience any negative outcomes. On October 7, 2015 a list of Do Not Crush medications was placed on each med cart and a copy at each nurse's station as reference. All licensed staff will be re-educated on the "Do not Crush" list and the medications are administered as prescribed in accordance with manufacturer's specifications, good nursing principles and practices by 11/22/15.</p> <p>3) A 100% audit of all "Do Not Crush" medications will be completed by 11/22/15 by the Director of Nursing, the Assistant Director of Nursing, the MDS nurse and the Unit manager. All new admissions will be reviewed by the Director of Nursing,</p>		

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F 281	<p>Continued From page 7</p> <p>b. In the absence of advance directives or a Do Not Resuscitate order; and</p> <p>c. If the resident does not show obvious signs of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition).</p> <p>3. CPR certified staff will be available at all times.</p> <p>4. Staff will maintain current CPR certification for healthcare providers through a CPR provider who evaluates proper technique through in-person demonstration of skills. CPR certification which includes an online knowledge component, yet still requires in-person skills demonstrations to obtain certification or recertification, is also acceptable.</p> <p>Record review revealed the facility admitted Resident #14 on 08/01/15 with diagnoses to include Colon Cancer, Abdominal Pain, and Chronic Airway Obstruction. Review of the Advanced Directives revealed the resident was to be a Full Code status.</p> <p>Review of a Nurse's Note, dated 09/21/15 at 2:00 PM, revealed Resident #14 was found by staff unresponsive. Chest compressions were initiated, then stopped, because, according to the nurse performing the chest compressions, stomach contents were expelled from the resident's mouth, and the resident's spouse (also the roommate but not the POA), asked the nurse to stop CPR. The nurse performing the chest compressions was not current on CPR certification.</p> <p>Interview with the Director of Nursing (DON), on 10/08/15 at 2:45 PM, revealed even though she was not present in the facility during the event on 09/21/15 with Resident #14, she had looked into</p>	F 281	<p>Assistant Director of Nursing and/or the MDS nurse weekly for any Do Not Crush medications to assure that the "Do Not Crush" medication has been identified and order states, Do Not Crush.</p> <p>4) A review of all current residents' advanced directives were reviewed by the Director of Nursing on October 8, 2015 to determine if all current residents' code status was identified and a physician's order present if the advanced directive was for a "Do Not Resuscitate". There were no concerns identified. In addition a comprehensive care plan was initiated for all current residents regarding code status. This was completed by Social Service Director on October 9, 2015. On October 26, 2015 the Director of Nursing observed Medication Administration and noted that medications including those indicated with label "do not crush" were administrated per order with no concerns identified. The facility has implemented the following system: On admission the code status of the resident will be</p>		

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F 281	<p>Continued From page 8</p> <p>the event, and determined the resident was deceased. She stated staff had initiated chest compressions, then stopped per the spouse's request; however, there was no documentation to verify all the details.</p> <p>2. Review of the facility's policy/procedure, "Medication Administration General Guidelines" Section 7.1, dated 2007, revealed medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube fed, using the following guidelines with a specific order from prescriber. The need for crushing medication is indicated on the resident's orders and the Medication Administration Record (MAR) so that all personnel administering medications are aware of this need and the consultant pharmacist can advise on safety and alternatives, if appropriate during Medication Regimen Reviews. Long acting, extended release or enteric-coated dosage forms should generally not be crushed, an alternative should be sought. Crush medications if indicated for the resident only after referring to the Medications Not To Be Crushed List. For products that appear on the Medications Not To Be Crushed List, check with the pharmacist regarding a suitable alternative, and request a new prescriber order if appropriate.</p> <p>Record Review revealed the facility admitted Resident #11 on 09/01/15 with diagnoses to include Dementia, Hypertension, Type II Diabetes, and Gastrointestinal Reflux.</p> <p>Observation of a medication pass for Resident</p>	F 281	<p>reviewed with the resident and or their responsible party to determine desired code status. At that time the appropriate paperwork will be completed if the resident or their responsible party wished to be a "Do Not Resuscitate". A care plan will be initiated by the Social Service Director and the physician contacted if there is a need for a "Do Not Resuscitate" order. The Admission team consisting of the Social Services Director and Business Office Manager were educated on this process by the Administrator and a competency test completed on October 8, 2015. On October 9, 2015 the Administrator re-educated the Interdisciplinary Team consisting of the Director of Nursing, MDS Nurse, Social Services Director, Activity Director, Dietary Services Manager, on the requirement to develop plan of care to meet the resident's needs to include medical condition, psychosocial needs, diagnosis and medications. On October 8, 2015 the Regional Quality Manager educated the</p>		

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F 281	Continued From page 9 #11, on 10/07/15 at 8:15 AM, revealed Registered Nurse (RN) #1 administered Metformin (Diabetic Medication) Extended Release (ER) 1000 milligrams (mg) one (1) tablet by mouth (po). Further observation revealed RN #1 crushed the Metformin ER 1000 mg prior to administration of the medication. Review of the MAR revealed no documentation to crush the Metformin according to the physician's order. Review of the medication card revealed a "do not crush" label on the card. Interview with RN #1, on 10/07/15 9:30 AM, revealed she was unaware of a "do not crush list being available". She further stated she was unaware the medication card for Metformin had "do not crush" on it, until this morning. She revealed the resident's family indicated they were crushing the resident's medication at home and had started crushing the medication after the resident had problems swallowing the medication. Interview with the DON, on 10/07/15 at 10:00 AM, revealed her expectation was for the nurses to follow the recommendation of the medications on the resident's medication card. She revealed if the medication card stated "do not crush", then her expectation was to not crush the medication, unless the medical provider was notified, and he or she obtained an order to crush it. She revealed crushing an extended release medication could lead to a potential problem with fast interacting of the medication. It may not be effective and could lead to the resident's blood sugar being out of range.	F 281	Director of Nursing on the requirement of a nurse to immediately begin CPR if the resident has designated to have CPR initiated per the 2010 American Heart Association healthcare setting guidelines for CPR. The Director of Nursing will re-educate all licensed staff on the requirement of a nurse to immediately begin CPR if the resident has designated to have CPR initiated per the 2010 American Heart Association healthcare setting guidelines for CPR on 10/9/15. All licensed staff was certified by AHA on 10/9/15. On October 9, 2015 the Human Resources Manager audited personnel records of all licensed staff to determine if their CPR status was current. No issues were found. A file will be maintained by HR to ensure CPR certification is current at all times for licensed staff. A reminder will be sent to the licensed nurse by HR 60 days prior to the expiration of the CPR certification. All staff will be offered the CPR certification class. All licensed staff will be re-		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309			

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F 309	<p>Continued From page 10</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure one (1) resident, in the selected sample of fifteen (15) residents (Resident #14), received the necessary care and services to maintain the highest practicable physical, mental and psychosocial well-being. The facility admitted Resident #14 with advance directives which revealed a desire for Cardiopulmonary Resuscitation (CPR). The resident was found unresponsive on 09/21/15 and chest compressions were initiated; however, were stopped per the resident's spouse (not the Power of Attorney) request, and stomach contents were expelled from the resident's mouth.</p> <p>The findings include: Review of the facility's policy/procedure, "Cardiopulmonary Resuscitation (CPR)", dated 02/17/15, revealed it is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement guidelines regarding cardiopulmonary resuscitation. Review of the guidelines revealed the following 1. The facility will follow current American Heart</p>	F 309	<p>educated by Director of Nursing or Assist Director of Nursing to facility's policy/procedure for medication administration to provide and meet professional standards of practice for quality to including "do not crush" by 11/22/2015. Monitoring of the plan of correction will be performed by the following: The Director of Nursing or Assistant Director of Nursing will audit all admission weekly to assure that code status has been identified and a care plan initiated. The Director of Nursing will conduct mock code drills weekly one each shift for four (4) weeks followed by weekly drills for eight (8) weeks. All monitoring will be reviewed monthly for (3) months by the Quality Assurance Committee for further recommendations if needed until substantial compliance is achieved. If at any time concerns are identified, a Quality Assurance Committee meeting will be convened to make further recommendations. The Quality Assurance Committee will consist of at a minimum, the</p>		

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F 309	<p>Continued From page 11</p> <p>Association (AHA) guidelines regarding CPR.</p> <p>2. If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and:</p> <ul style="list-style-type: none"> a. In accordance with the resident's advance directives, or b. In the absence of advance directives or a Do Not Resuscitate order; and c. If the resident does not show obvious signs of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition). <p>3. CPR certified staff will be available at all times.</p> <p>4. Staff will maintain current CPR certification for healthcare providers through a CPR provider who evaluates proper technique through in-person demonstration of skills. CPR certification which includes an online knowledge component, yet still requires in-person skills demonstrations to obtain certification or recertification, is also acceptable.</p> <p>Record review revealed the facility admitted Resident #14 on 08/01/15 with diagnoses to include Colon Cancer, Abdominal Pain, and Chronic Airway Obstruction. Review of the Advanced Directives revealed the resident was to be a Full Code status.</p> <p>Review of the Advanced Directives documentation, dated 08/01/15, revealed the POA signed for the resident to be a full code in the event of cardiac arrest. Review of the CPR section revealed "I am expressing a desire to have Cardiopulmonary Resuscitation to be done in the event of cardiac arrest. I understand that in the event of an observed or unobserved cardiac</p>	F 309	<p>Administrator, Director of Nursing, the Assistant Director of Nursing, the MDS nurse, Social Services Director and Medical Director attending at least quarterly. Failure to comply with any of the above will result in individual re-training and as appropriate, disciplinary action. The Director of Nursing, Assistant Director of Nursing, Unit Manager or MDS nurse will conduct medication administration observation/audits three (3) times per week for twelve (12) weeks to ensure Medication Administration policy/procedures are being provided and meet professional standard. These observations/audits will be reviewed with the Quality Assurance Committee monthly x three (3) months. If at any time concerns are identified, the facility will convene a Quality Assurance Committee meeting to review for further recommendations as needed. The Quality Assurance Committee will consist of at a</p>	

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F 309	<p>Continued From page 12 arrest, CPR will be initiated by staff and emergency personnel will be called".</p> <p>Review of a Nurse's Note, dated 09/21/15 at 2:00 PM, revealed Resident #14 was found by staff unresponsive, and chest compressions were initiated; however, no code was called. Chest compressions were stopped because, according to the nurse who performed the chest compressions, stomach contents were expelled from the resident's mouth and the resident's spouse (also the roommate but not the POA asked her to stop. The nurse who performed the chest compressions was not current on CPR certification.</p> <p>Review of a Nurse's Note, dated 09/21/15 at 4:47 PM, revealed documentation by Registered Nurse (RN) #2 to "see discharge disposition". Review of the Discharge Disposition form, dated 09/21/15 at 2:00 PM, revealed documentation by RN #2 which stated, "Resident expired at approximately 2:00 PM. No vital signs present. Verified by two (2) RNs. Chest compressions were given until rust colored contents expelled from his/her mouth, and the resident's spouse was in the room crying, saying stop I want to see my husband".</p> <p>Interview with the Director of Nursing (DON), on 10/08/15 at 2:45 PM, revealed, on 09/21/15, she was out of the facility and when she returned, she was notified Resident #14 was deceased. She stated staff initiated CPR and his/her spouse requested the staff stop CPR; however, there was no documentation to verify this information. She revealed she looked into it and RN #2 performed chest compressions and stopped when the spouse requested, but she would have expected</p>	F 309	<p>minimum the Director of Nursing, the Assistant Director of Nursing, MDS nurse, the Social Service Director and the Administrator with the Medical Director attending at least quarterly. 5) Completion date is 11/22/15.</p> <p>F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>1) The resident identified as resident # 14 expired at facility on 9/21/15. 2) A review of all current residents' advanced directives were reviewed by the Director of Nursing on October 8, 2015 to determine if all current residents' code status was identified and a physician's order present if the advanced directive was for a "Do Not Resuscitate". There were no concerns identified. This was completed by SSD on 10/9/15. In addition a comprehensive care plan was initiated for all current residents regarding code status.</p>	11/23/15
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F 309	<p>Continued From page 13</p> <p>RN #2 to continue CPR. Additionally, she revealed if a resident was determined to be Full Code status, it should be in the resident's record. She stated staff were to call a Code, get the crash cart, initiate CPR, call 911, and continue until EMS arrived, or until the physician or the POA said to stop CPR.</p> <p>Interview with RN #2, on 10/08/15 at 3:20 PM, revealed, on 09/21/15, she was summoned to Resident #14's room. RN #2 revealed she observed the resident in the bathroom, sitting upright on the commode with his/her face, arms, and legs "blotchy" in color and skin cool to touch. The resident was moved to his/her bed and his/her legs were hard to straighten out and lay flat. RN #2 could not recall how she knew the resident was a full code, but "just knew" and started chest compressions. She revealed she stopped compressions when "stuff" came out of the resident's mouth. RN #2 stated she was unsure when not to initiate CPR, when a resident was a full code. She stated the facility had a procedure, but she would have to review it to know when not to initiate CPR, when CPR can be stopped, or if she was supposed to call 911. RN #2 revealed she was not current in CPR certification.</p> <p>Interview with RN #1, on 10/08/15 at 4:25 PM, revealed, on 09/21/15, a Certified Nurse Aide (CNA) ran out of Resident #14's room saying a nurse was needed immediately. RN #1 entered Resident #14's room and observed the resident in the bathroom on the commode unresponsive, grey in color, and skin cool to touch. No pulse was present and there was no chest rise indicating breathing. The resident was moved to the bed and RN #2 started chest compressions,</p>	F 309	<p>On 10/26/15 the Director of Nursing completed an audit on all current residents for code status and care plan. No issues were found. All new admissions will be reviewed and care plan will be initiated upon admission by Social Service Director and will be reviewed quarterly and as needed with any change in condition by Interdisciplinary Team will consist of at least DON, MDS and SSD.</p> <p>3) The facility has implemented the following system: On admission the code status of the resident will be reviewed with the resident and or their responsible party to determine desired code highest well being status. At that time the appropriate paperwork will be completed by the resident's or their responsible party's wishes to be a "Do Not Resuscitate". A care plan will be initiated by Social Service Director and the physician contacted if there is a need for a "Do Not Resuscitate" order. The Admission team consisting of the Social Services Director and Business Office Manager were</p>		

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F 309	<p>Continued From page 14</p> <p>but RN #1 did not inflate any breaths. They stopped CPR because Resident #14's spouse was behind the privacy curtain, stating to stop CPR, he/she was gone. RN #1 stated the spouse was not the resident's POA. RN #1 revealed no one asked for the crash cart, and did not know what was on the crash cart, and was unsure if 911 was called. She stated if she had known the resident was a full code, she would not have stopped.</p> <p>Interview with CNA #2, on 10/09/15 at 8:50 AM, revealed, on 09/21/15, she was obtaining residents' weights and when she knocked on Resident #14's room, his/her spouse stated he/she was looking for Resident #14. CNA #2 stated she looked in the bathroom and saw Resident #14 leaned back, sitting on the commode with his/her mouth open, so CNA #2 ran to a hall phone and paged for a nurse to come to his/her room. RN #1 came to the room and CNA #2 took Resident #14's spouse to the other side of the room behind the privacy curtain in an attempt to console him/her. CNA #2 revealed a code was not called and she did not hear or see any activity that was like a code. She revealed Resident #14's spouse did not tell the staff who were with Resident #14 to stop CPR, and had only requested to see Resident #14.</p> <p>Interview with CNA #3, on 10/09/15 at 9:35 AM, revealed she was assigned to Resident #14 on 09/21/15 but did not find the resident in the bathroom. CNA #3 revealed she assisted in moving Resident #14 back to the bed. She stated the resident's skin was white, and no one initiated a code or did CPR. She did not recall anyone discussing a code status. CNA #3 revealed she last saw Resident #14 about 1:00 PM and stated</p>	F 309	<p>educated on this process by the Administrator and a competency test completed on October 8, 2015. On October 9, 2015 the Administrator re-educated the Interdisciplinary Team consisting of the Director of Nursing, MDS Nurse, Social Services Director, Activity Director, Dietary Services Manager, on the requirement to develop plan of care to meet the resident's needs to include medical condition, psychosocial needs, diagnosis and medications. On October 8, 2015 the Regional Quality Manager educated the Director of Nursing on the requirement of a nurse to immediately begin CPR if the resident has designated to have CPR initiated per the 2010 American Heart Association healthcare setting guidelines for CPR. The Director of Nursing will re-educate all licensed staff on the requirement of a nurse to immediately begin CPR if the resident has designated to have CPR initiated per the 2010 American Heart Association healthcare setting guidelines for</p>		

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F 309	Continued From page 15 he/she did not need anything at that time. Interview with RN #3, on 10/09/15 at 10:40 AM, revealed when she arrived to Resident #14's room, he/she was already on the bed and was "stiff and white" and staff were performing post mortem care. Someone asked her to phone the resident's physician and daughter. She notified the physician and reported the resident had expired. RN #3 was unaware if 911 was called and did not discuss the code status of Resident #14 with anyone. Additional interview with the DON, on 10/09/15 at 11:40 AM, revealed the facility was responsible to ensure staff keep his or her CPR certification current. A previous employee was contracted to provide CPR recertification when the facility staff required it. She was unable to provide verification that one hundred percent (100%) of the licensed staff were current in CPR certification.	F 309	CPR, all licensed staff were certified by AHA on 10/9/15. On October 9, 2015 the Human Resources Manager audited personnel records of all licensed staff to determine if their CPR status was current. No issues were found. A file will be maintained by HR to ensure CPR certification is current at all times for licensed staff. A reminder will be sent to the licensed nurse by HR 60 days prior to the expiration of the CPR certification. All staff will be offered the CPR certification class. Audit on 10/12/15 by Director of Nursing on current/active nurses to validate CPR certification and no issues were found. 4) Monitoring of the plan of correction will be performed by the following: The Director of Nursing or Assistant Director of Nursing will audit all admission weekly to assure that code status has been identified and a care plan initiated. The Director of Nursing will conduct mock code drills weekly one each shift for four (4) weeks followed by		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, the facility failed to ensure one (1) resident, in the selected sample of fifteen (15) residents (Resident #11), was free from a significant medication error related to inappropriate crushing	F 333			

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F 333	<p>Continued From page 16 of a medication (Metformin).</p> <p>The findings include:</p> <p>Review of the facility's policy/procedure, "Medication Administration General Guidelines" Section 7.1, dated 2007, revealed medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube fed, using the following guidelines with a specific order from prescriber. The need for crushing medication is indicated on the resident's orders and the Medication Administration Record (MAR) so that all personnel administering medications are aware of this need and the consultant pharmacist can advise on safety and alternatives, if appropriate during Medication Regimen Reviews. Long acting, extended release or enteric-coated dosage forms should generally not be crushed, an alternative should be sought. Crush medications if indicated for the resident only after referring to the Medications Not To Be Crushed List. For products that appear on the Medications Not To Be Crushed List, check with the pharmacist regarding a suitable alternative, and request a new prescriber order if appropriate.</p> <p>Record Review revealed the facility admitted Resident #11 on 09/01/15 with diagnoses to include Dementia, Hypertension, Type II Diabetes, and Gastrointestinal Reflux.</p> <p>Observation of a medication pass for Resident #11, on 10/07/15 at 8:15 AM, revealed Registered Nurse (RN) #1 administered Metformin (Diabetic</p>	F 333	<p>weekly drills for eight (8) weeks. All monitoring will be reviewed monthly for three (3) months by the Quality Assurance Committee for further recommendations if needed until substantial compliance is achieved. If at any time concerns are identified, a Quality Assurance Committee meeting will be convened to make further recommendations. The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, the Assistant Director of Nursing, the MDS nurse, Social Services Director and Medical Director attending at least quarterly. Failure to comply with any of the above will result in individual re-training and as appropriate, disciplinary action.</p> <p>5) Completion date is 11/22/15.</p> <p>F 333 RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p>	11/23/15	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185329	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2015
NAME OF PROVIDER OR SUPPLIER MORGANFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH CARRIER ST. MORGANFIELD, KY 42437		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 17</p> <p>Medication) Extended Release (ER) 1000 milligrams (mg) one (1) tablet by mouth (po). Further observation revealed RN #1 crushed the Metformin ER 1000 mg prior to administration of the medication. Review of the MAR revealed no documentation to crush the Metformin according to the physician's order. Review of the medication card revealed a "do not crush" label on the card.</p> <p>Interview with RN #1, on 10/07/15 9:30 AM, revealed she was unaware of a "do not crush" list being available. She stated she was unaware the medication card for Metformin had "do not crush" on it, until this morning. She revealed the resident's family indicated they were crushing the resident's medication at home and had started crushing the medication after the resident had problems swallowing the medication. She also revealed she started crushing the medication after the resident started holding the medication in his/her mouth. She stated no one updated the E-MAR, it was something passed on to each other in report.</p> <p>Interview with Pharmacist #1, on 10/07/15 at 10:15 AM, revealed if the medication (Metformin ER) was crushed, the efficacy could be affected, and if the resident remained on the medication for an extended amount of time, it could interfere with the effectiveness of the medication.</p> <p>Interview with the Pharmacy Director, on 10/07/15 at 11:00 AM, revealed the medication (Metformin ER), does have to be swallowed whole, and the effect, if crushed, would be Gastrointestinal (GI) upset. She revealed the Extended Release medication was released over an extended amount of time and if the outer coating was</p>	F 333	<p>1) On 10/7/15, Resident #11's physician was notified and changed medication to a crushable medication. Pharmacy was called by the Director of Nursing on 10/7/15 to request the list of "Do Not Crush" medications and list was placed on the medication carts and at both nurses stations. Registered Nurse (RN#1) was re-educated by Director of Nursing on 10/7/15 to the professional standards of Quality related to the facility's Medication Administration policy/procedure to check the "Do Not Crush" list and the notation on the Medication Card that states "Do Not Crush".</p> <p>2) The Director of Nursing, Assistant Director of Nursing, Unit Manager and MDS nurse audited all residents that were "Do Not Crush" on medication cards to ensure compliance. On 10/28/15, the Director of Nursing observed Medication Administration and noted that medications including "Do Not Crush" were administered per physician order with no concerns identified.</p>		

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NAME OF PROVIDER OR SUPPLIER MORGANFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 809 NORTH CARRIER ST. MORGANFIELD, KY 42437		
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F 333	Continued From page 18 compromised, it would not get the sustained blood level of the drug. She further revealed the pharmacy sent the "do not crush" list to the facility, and was to be kept on each medication cart and documented on the auxiliary label of the medication card. She stated the facility was responsible to provide the nurses with education related to the "do not crush" list. Interview with the Director of Nursing (DON), on 10/07/15 at 11:15 AM, revealed it was the pharmacy's responsibility to provide the "do not crush" list, and it was her responsibility to ensure the list was at the nurse's station. She revealed the facility currently does not have a copy of the "do not crush" list provided by the pharmacy. She revealed her expectations were for the nurses to follow the medical providers' orders related to medication administration. She stated she expected nursing staff to look at the labels on the medication being administered, as well as the body of the order for instructions. The medical provider would have to write an order for a medication to be crushed, or change the medication to a crushable form.	F 333	3) All licensed staff will be re-educated to facility's policy/procedure for medication administration to provide and meet professional standards of practice for quality to include the list of "Do Not Crush" medications are on each medication cart and at each nurses station as well as on the resident's Medication Card by the Director of Nursing by 11/22/15.		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	4) Director of Nursing, Assistant Director of Nursing, Unit Manager or MDS Nurse will conduct medication administration observation/audits three (3) times per week for twelve (12) weeks to ensure Medication Administration policy/procedures are being provided and meet professional standards. These observations/audits will be reviewed with the Quality Assurance Committee monthly x three (3) months. If at any time concerns are identified, the facility will convene a Quality Assurance meeting to review for		

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F 371	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure food was stored, prepared and served under sanitary conditions. Observations on 10/06/15 and 10/07/15, revealed bottles of unlabeled, partly consumed beverages in the residents' refrigerator, and on the food prep counter of the tray line. The findings include: Interview with the Dietary Manager, on 10/08/15 at 11:00 AM, revealed there was no specific policy/procedure related to storing employee food or beverages in the kitchen refrigerators. Review of the facility's policy/procedure, "Food Brought Into Residents' Rooms From Outside Sources", undated, revealed foods or beverages brought in from the outside should be labeled with name, room number, and date. Observation during the initial tour of the kitchen, on 10/06/15 at 10:00 AM, revealed an opened bottle of soda and an opened bottle of Smart Water. The soda and water were only half full and there was no label indicating the opened date, or a name. Interview with the Dietary Manager, at the time of the observation, revealed the bottles should not be in the residents' refrigerator. Further observation, on 10/07/15 at 12:35 PM,	F 371	further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, the Assistant Director of Nursing, MDS nurse, the Social Service Director and the Administrator with the Medical Director attending at least quarterly. 5) Completion date is 11/22/ 2015. F 371 FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY 1) On October 6, 2015 the bottles of unlabeled, partly consumed beverages in residents' refrigerator were removed by dietary manager. On October 7, 2015 the half bottle of unlabeled water sitting on the food prep surface of the tray line was removed by dietary manager. On 10/26/15 the Administrator re-educated the Dietary	11/23/15

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NAME OF PROVIDER OR SUPPLIER MORGANFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH CARRIER ST. MORGANFIELD, KY 42437		
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F 371	Continued From page 20 revealed a half full bottle of unlabeled water sitting on the food prep surface of the tray line. Interview with the Dietary Manager, at the time of the observation, revealed the water belonged to her and she had "just sat it down without thinking". She stated it should not be on the resident's food preparation surface. Interview with the Director of Nursing (DON), on 10/08/15 at 1:50 PM, revealed opened unlabeled bottles of any beverage should never be in the residents' refrigerator or on any food preparation area. She stated the employee break room had a refrigerator for employee use.	F 371	Manager to ensure that that food will be stored, prepared and served under sanitary conditions. That kitchen/resident refrigerator and food prep counter are to be free from any opened drinks that belong to staff.		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was	F 514	2) On 10/26/15, the Administrator made rounds in the kitchen to ensure that there were no open drinks for staff in the kitchen. 3) All dietary staff will be re-educated by Administrator to the facility's policy/procedure for storing food properly and not allowing staff to put any drinks in the residents' refrigerator and that all items are labeled and dated properly. 4) Dietary Manager and/or Dietary Cook will do a daily "Quick Kitchen Sanitation Round" forms to ensure that no employee drinks are left in the residents' refrigerator		

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NAME OF PROVIDER OR SUPPLIER MORGANFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH CARRIER ST. MORGANFIELD, KY 42437		
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F 514	<p>Continued From page 21</p> <p>determined the facility failed to ensure the clinical record for one (1) resident, in the selected sample of fifteen (15) residents (Resident #14), was complete and accurately documented related to events occurring after the resident experienced a cardiac event on 09/21/15.</p> <p>The findings include:</p> <p>A policy/procedure related to maintaining clinical records was not provided by the facility. Interview with the Director of Nursing (DON), on 10/09/15 at 2:45 PM, revealed she was unaware if there was a specific facility policy/procedure related to documentation.</p> <p>Record review revealed the facility admitted Resident #14 on 08/01/15 with diagnoses to include Colon Cancer, Abdominal Pain, and Chronic Airway Obstruction. Further review revealed the Advanced Directives were signed by the resident's Power of Attorney (POA) on 08/01/15, indicating the desire for the resident to be provided CPR in the event the resident's breathing and/or heart function ceased. Review of the CPR section revealed "I am expressing a desire to have Cardiopulmonary Resuscitation to be done in the event of cardiac arrest. I understand that in the event of an observed or unobserved cardiac arrest, CPR will be initiated by staff and emergency personnel will be called".</p> <p>Review of a Nurse's Note, dated 09/21/15 at 4:47 PM, revealed documentation by Registered Nurse (RN) #2 to "see discharge disposition". Review of the Discharge Disposition form, dated 09/21/15 at 2:00 PM, revealed documentation by RN #2 which stated, "Resident expired at approximately 2:00 PM. No vital signs present.</p>	F 514	<p>or on the food prep counter. These daily audits/check list will be done daily for 12 weeks to ensure that dietary is in compliance. These observations/audits will be reviewed with the Quality Assurance Committee monthly x three (3) months. If at any time concerns are identified, the facility will convene a Quality Assurance Committee meeting to review for further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, the Assistant Director of Nursing, the Dietary Manager and the Administrator with the Medical Director attending at least quarterly.</p> <p>5) Completion date is 11/22/15</p>	11/23/15	

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NAME OF PROVIDER OR SUPPLIER MORGANFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH CARRIER ST. MORGANFIELD, KY 42437		
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F 514	<p>Continued From page 22</p> <p>Verified by two (2) RNs. Chest compressions were given until rust colored contents expelled from his/her mouth, and the resident's spouse was in the room crying, saying stop I want to see my husband".</p> <p>Further review of the resident's record revealed there was no documentation in the Nurse's Notes related to the event surrounding the resident being found unresponsive or measures taken and by whom.</p> <p>Interview with the DON, on 10/09/15 at 2:45 PM, revealed she expected to see more detailed documentation of the event other than on the Discharge Disposition form.</p>	F 514	<p>F 514 RECORDS-COMplete/ACCURATE/ACC ESSIBLE</p> <p>1) The resident identified as resident # 14 expired on 9/21/15 in the facility.</p> <p>2) RN #2 was educated on 10/26/2015 by Director of Nursing to the clinical record must contain sufficient information to include complete and accurate documentation related to events of residents.</p> <p>3) All licensed staff will be re-educated by the Director of Nursing to document accurate and functional representation of the actual experience of the resident in the facility by 11/22/15.</p> <p>4) The Director of Nursing and Administrative Nurses will perform audits on three (3) charts daily x four (4) weeks and then two (2) charts weekly x eight (8) weeks to ensure that any resident with any events, documentation is accurate and</p>		

complete to represent a true picture of that event. All monitoring will be reviewed monthly for three (3) months by the Quality Assurance Committee for further recommendations if needed until substantial compliance is achieved. If at any time concerns are identified, a Quality Assurance Committee meeting will be convened to make further recommendations. The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, the MDS nurse, Social Services Director and Medical Director attending at least quarterly. Failure to comply with any of the above will result in individual re-training and as appropriate, disciplinary action.

5) Completion date is 11/22/2015.

11/23/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185329	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 11/25/2015
NAME OF PROVIDER OR SUPPLIER MORGANFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH CARRIER ST. MORGANFIELD, KY 42437		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance on 11/22/15, as alleged.	{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185329	(Y2) Multiple Construction A. Building 01 - MAIN BUILDING 01 B. Wing	(Y3) Date of Revisit 11/25/2015
Name of Facility MORGANFIELD NURSING & REHABILITATION CENTER		Street Address, City, State, Zip Code 509 NORTH CARRIER ST. MORGANFIELD, KY 42437

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0144	Correction Completed 11/22/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <i>CM</i>	Date: <i>11/30/15</i>	Signature of Surveyor: <i>Carol Macintosh, ARPM</i>	Date: <i>11/30/15</i>
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/6/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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NAME OF PROVIDER OR SUPPLIER MORGANFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH CARRIER ST. MORGANFIELD, KY 42437
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K 000	<p>INITIAL COMMENTS</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1985.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1986, and upgraded in 1992 with 19 smoke detectors and 114 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1986 and upgraded in 1998.</p> <p>GENERATOR: (2) Type II generators installed in 2009. Fuel source is Diesel.</p> <p>A standard Life Safety Code Survey was conducted on 10/08/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty (60) beds with a census of fifty-five (57) 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 Fire).</p>	K 000	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegations by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of requirement under state and federal law that mandate submission of a plan of correction within the (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this time frame should in no way be construed or considered as an</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Mary L Wood* TITLE *Administrator* (X6) DATE *11/25/15*

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 MORGANFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH CARRIER ST. MORGANFIELD, KY 42437	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000	<p>agreement with the allegations of noncompliance or admission by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p> <p>K 144 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>1) The generator transfer switch was tested on Monday, October 26, 2015 by Maintenance Supervisor with generator service vendor Safe Care supervising.</p> <p>2) An audit was conducted by Regional Director of Maintenance on Monday, October 26, 2015 with Maintenance Supervisor and Safe Care to ensure that the generator transfer switch cycled the load from the standard position to the alternate position and then returned to the standard position as required by NFPA 100, 1999 edition.</p> <p>3) On October 28, 2015 the regional plant operations</p>	
K 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on an interview, the facility failed to maintain the generator set by National Fire Protection Agency (NFPA) standards. This deficient practice affected four (4) of four (4) smoke compartments, staff and all the residents. The facility has the capacity for 60 beds with a census of 57 the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey, on 10/06/15 at 2:00 PM, an interview with the Plant Operations Manager at the generator transfer switch revealed he was not aware the generator transfer switch should be manually tested on a monthly basis as required. This type of testing helps ensure the generator transfer switch is operating as intended.</p> <p>The findings were revealed to the Administrator</p>	K 144		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185329	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/06/2015
NAME OF PROVIDER OR SUPPLIER MORGANFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 809 NORTH CARRIER ST. MORGANFIELD, KY 42437	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 2 upon exit. Reference: NFPA 110 1999 edition 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.	K 144	manager conducted training with the Maintenance Supervisor to ensure that he was aware of the requirements and methods of testing to maintain compliance with NFPA 110, 1999 edition. 4) Continued testing on a minimum monthly basis x 3 months and will be monitored through the Tels program to ensure compliance. 5) Completion date of 11/22/15	<i>11/2/15</i>