STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185329	A. BUILDING _____ B. WING _____	R 05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANFIELD NURSING AND REHABILITATION CENTER	509 NORTH CARRIER STREET 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	{F 000}		

Based upon the implementation of the acceptable Plan of Correction (PoC), the facility compliance for health on 04/23/2025.

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.

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	185329	A. BUILDING _____ B. WING _____	04/04/2025

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A Standard Recertification survey was concluded on 04/04/2025. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Deficiencies were cited with the highest scope and severity of an "E".

Survey Dates: 04/01/2025-04/04/2025
Survey Census: 53
Sample Size:14

F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		4/23/25

§483.45(g) Labeling of Drugs and Biologicals
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 761	Continued From page 1 This REQUIREMENT is not met as evidenced by:	F 761		

Based on observation, interview, facility policy review, and review of manufacturer's instructions, the facility failed to ensure drugs and/or biologicals used in the facility were current for use and/or labeled in accordance with currently accepted professional principles, including the expiration date when applicable. A review of one medication storage room and one of two medication carts revealed that a Tuberculin vial stored in the medication storage room refrigerator was opened but not labeled with a date so as to calculate its discard date.

The findings include:

Review of a facility policy titled, "Label/Store Drugs and Biologicals Standard of Practice," reviewed 10/2020, revealed drugs and biologicals must be labeled in accordance with currently accepted professional principles, including the expiration date when applicable. The policy further stated if a multi-dose vial was opened or accessed, the vial should be dated and discarded within 28 days unless the manufacturer specified a different date for the specific vial.

Observation on 04/04/2025 at 10:30 AM of the medication storage room on Hall 2 revealed a "house stock" multi-dose vial of Aplisol tuberculin 5TU/0.1milliliters (ml) that was opened but was not dated. Review of manufacturer guidelines from PAR Pharmaceuticals (the manufacturer listed on the box containing the vial) revealed that vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency.

F761

1. On 4/4/25, the Charge Nurse removed the opened, unlabeled vial of tuberculin from the medication room refrigerator and discarded. No specific resident was identified in the statement of deficiencies.
2. Resident with orders for a tuberculin skin test would have the potential to be affected by the identified deficient practice. On 4/4/2025, the Charge Nurse audited the medication room refrigerator for any additional items that may be unlabeled opened/accessed and none were identified.
3. Licensed nurses, including agency licensed nurses, and certified medication aides received education on the regulatory intent of F761, including that any time a multi-dose vial is opened/accessed, the vial is to be dated as to calculate the date it should be discarded based on facility policy and/or manufacturers specifications. This education was provided by Regional Clinical Manager and Director of Nursing. Understanding of content was validated through verbal exchange between instructor and participants. This education was completed on 4/22/25. Any newly hired licensed nurse or medication aide, or contracted agency licensed nurse, shall receive this education as part of the orientation process. The facility does not utilize agency certified medication aides.
4. Beginning 4/18/25, the Director of Nursing, Assistant Director of Nursing or

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F 761	Continued From page 2 During an interview with Licensed Practical Nurse (LPN) 2 on 04/04/2025 at 10:40 AM, she stated when vials were opened, they should be dated with the date opened and then should be discarded in 30 days. LPN2 stated since the vial was not dated, it should be discarded, adding that if it was used, it may not be as effective. During an interview with the Interim Director of Nursing/Regional Quality Manager (DON) on 04/04/2025 at 2:51 PM, she stated the expectation was that any vial or box be dated immediately upon opening, then it should be monitored for the appropriate discard date. She stated the drug may not be as effective and she would worry about infections, organisms, and growth. During an interview with the Administrator on 04/04/2025 at 3:21 PM, she stated she expected staff to follow facility policy to ensure proper protocols related to vials being dated when opened were followed, as the facility did not want to do things outside of the manufacturer's guidance.	F 761	RN Supervisor will complete a weekly audit of each medication room/storage area to ensure each opened/accessed multi-use vial or medication has been dated to monitor and calculate the discard date. This will continue weekly for 12 weeks. Any identified issue will be addressed at the time of discovery. The Director of Nursing, Assistant Director of Nursing, or RN Supervisor will report the results of the audit to the Quality Assurance and Process Improvement committee for 3 months for review and recommendation. The facility QAPI Committee consists of, but is not limited to, the Administrator, Director of Nursing, Infection Preventionist, Social Services, MDS, Activities Director, Dietary Manager, and the Medical Director. 5. Compliance date (4/23/2025)	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		4/23/25

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	185329	A. BUILDING _____ B. WING _____	04/04/2025

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F 880	Continued From page 3	F 880		

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which 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; and

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F 880	Continued From page 4	F 880		

(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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 provide an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections for four (Resident (R)31, R37, R50, and R155). of 14 sampled residents. Staff failed to perform hand hygiene when indicated during wound care and medication administration, as well as clean multi-resident use equipment as indicated.

The findings include:

1. Review of an undated facility policy titled, "Hand Hygiene," revealed hand hygiene should be by using either handwashing, antiseptic hand wash, or antiseptic hand rub. and should be performed before and after glove use. The policy further stated gloves should be changed and

F880
1. There were no negative outcomes for Residents #31, # 37, #50, or #155 as there was no change in physical baseline as a result of the identified deficient practice. The Interim Director of Nursing provided 1:1 education to LPN #1 on 4/3/25 and LPN #2 on 4/4/25 regarding the specific identified opportunities of washing hands between glove changes, not touching medication during medication pass and/or discarding medication that comes in contact with any surface except the medication cup, and the need to ensure multi-resident use equipment is cleaned between residents.
2. All residents would have the potential to be affected by the identified deficient practice.
3. The Regional Clinical Manager and

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F 880	Continued From page 5 hand hygiene performed before moving from a contaminated-body site to a clean-body site during resident care. Record review of an Admission Face Sheet revealed the facility admitted R50 on 02/06/2025 with diagnoses including an unstageable pressure ulcer of the right buttock and type 2 diabetes mellitus. An observation of wound care for R50's pressure ulcer of the right buttock was conducted with Licensed Practical Nurse (LPN) 2 on 04/04/2025 at 9:31 AM. LPN 2 donned gloves prior to performing wound care; however, she failed to perform hand hygiene after removing soiled gloves three separate times. During an interview with LPN 2 on 04/04/2025 at 11:30 AM, she stated she should have washed her hands between glove changes, indicating that this failure could have contaminated R50's wound. During an interview with the Infection Prevention (IP) Nurse on 04/04/2025 at 2;00 PM, she stated she expected staff to always wash their hands between glove changes. She stated handwashing and having precautions in place would help prevent infections and stop the spread of infections. During an interview with the interim Director of Nursing/Regional Quality Manager (DON) on 04/04/2025 at 2:51 PM, she stated she expected staff to follow handwashing guidelines and infection control guidelines and protocols for all care including wound care. She stated if the guidelines were not followed, it would increase	F 880	Director of Nursing provided education to licensed nurses, including licensed agency nurses, and medication aides, on the regulatory intent of F880, including that hands should be cleaned/sanitized before and after medication administration between residents and after removing soiled gloves, that medication should be punched from the packaging directly into the medication cup, not to be touched by bare hands and to be discarded/replaced if the medication comes in contact with another surface, and that reusable shared medical equipment is to be cleaned between residents according to manufacturer's instructions. Understanding was validated through verbal exchange between instructor and participant as well as through an instructor-observed nurse return skill competency completed by participants. This education was completed on 4/22/25. Any newly hired licensed nurse, contracted agency licensed nurse or medication aides shall receive this education as part of the orientation process. 4. Beginning 4/22/25, the Director of Nursing, Assistant Director of Nursing or RN Supervisor will observe a minimum of 2 opportunities of licensed nurses completing wound care and a minimum of 2 opportunities of licensed nurses or medication aides completing medication pass administration weekly for 12 weeks to validate appropriate infection control technique with hand washing, medication dispensing for administration, and cleaning of shared equipment between	

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F 880	Continued From page 6	F 880		

the risk for infection and that would be her concern, adding R50's wound could have been contaminated.

During an interview with the Administrator on 04/04/2025 at 3:21 PM, she stated she expected staff to perform proper handwashing because that is the best prevention of contamination.

2. Review of the facility policy titled, "Medication Administration Standard of Practice," with a review date of 10/2020, revealed that staff shall follow established infection control procedures for the administration of medications, as applicable.

a. Observation on 04/03/2025 at 8:20 AM revealed LPN1 preparing medications for R31. While removing R31's Calcium Carbonate/Vitamin D3 from the multi-dose blister card, the tablet fell onto the top of the medication cart. LPN1 then, with a bare hand, picked up the tablet and placed it into the medication cup for administration. Additionally, LPN1 removed a Clonazepam 1 milligram (mg) tablet from the multi-dose blister card into her bare hand and placed the tablet into the medication cup, then proceeded to administer it to R31.

b. Continued observation of LPN1, while preparing medications on 04/03/2025 at 8:35 AM, revealed LPN1 dropped R155's 1/2 tablet of Entresto out of the multi-dose blister card onto the top of the medication cart. LPN1 then used a bare hand to place the tablet into the medication cup for R155. Ongoing observation revealed LPN1 also used a bare hand to place R155's Sinemet tablet into the medication cup.

c. After administering medication to R31, LPN1

residents. Any identified issue will be addressed at the time of discovery. The Director of Nursing, Assistant Director of Nursing or RN Supervisor will report the results of the audit to the Quality Assurance and Process Improvement committee for 3 months for review and recommendation. The facility QAPI Committee consists of, but is not limited to, the Administrator, Director of Nursing, Infection Preventionist, Social Services, MDS, Activities Director, Dietary Manager, and the Medical Director.
5. Compliance date: 4/23/2025

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F 880	Continued From page 7	F 880		

then returned to the medication cart. At 8:48 AM, LPN1 failed to perform hand hygiene and began to prepare medications for R37.

In an interview with LPN1 on 04/03/25 at 9:01 AM, she stated she received one or two days of training as an LPN at the facility. LPN1 stated the top of the medication cart is wiped off at the start of the shift, but she probably should get another pill if one is dropped on the top of the medication cart when preparing medications. LPN1 related that hand hygiene would be important to do between residents to prevent the spread of infection.

3. Review of the facility policy titled, "Policies and Practices - Infection Control," with a revision date of 10/ 2018, revealed that an objective of the infection control policies and practices are to provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment. No policy that described the actual processes for cleaning of specific resident-care equipment was provided prior to exit from the facility.

Observation revealed that during the medication pass for R155 which began on 04/03/2025 at 8:35 AM, LPN1 used a reusable electronic wrist blood pressure cuff to perform a blood pressure check for both R31 and R155 without cleaning the equipment between residents.

In an interview with LPN1 on 04/03/25 at 9:01 AM, she stated the blood pressure cuff "probably should be" cleaned between residents but "no one explained that."

In an interview with the IP Nurse on 04/04/25 at

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F 880	Continued From page 8	F 880		

2:03 PM, she stated she would expect the nurses to complete hand hygiene and clean reusable equipment to prevent the spread of infection. The IP Nurse indicated that that in-services on handwashing are provided yearly and as needed, adding that nursing staff are educated on infection prevention during the quarterly nursing meetings.

In an interview with the interim DON on 04/04/25 at 2:53 PM, she stated it was her expectation to follow handwashing and infection control and protocols for all tasks including wound care and medication administration.

In an interview with the Administrator on 04/04/25 at 3:56 PM, she stated that it was her expectation for staff to follow infection control and prevention policies to prevent the spread of infection.

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	185329	A. BUILDING 01 - MAIN BUILDING 01 B. WING	R 05/13/2025

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{K 000}	INITIAL COMMENTS	{K 000}		

Based on the acceptable Plan of Correction (POC) and the onsite revisit survey initiated and concluded on 05/13/2025, it was determined the facility had achieved substantial compliance with Life Safety Code on 04/18/2025.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	185329	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/01/2025**

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42 CFR 483.90(a)
K3 BUILDING: 0101
K6 PLAN APPROVAL: 1965
K7 SURVEY UNDER: 2012 Existing
K8 SNF/NF

Type of Structure: One (1) story, (1965), Type III (211), protected ordinary construction with four (4) smoke compartments and a complete automatic dry sprinkler system.

A Life Safety Recertification Survey was initiated on 04/01/2025 and concluded on 04/01/2025, in accordance with 42 Code of Federal Regulations (CFR), Subpart 483:90(a) Requirements for Long Term Care Facilities. During this Recertification Survey, Morganfield Nursing and Rehabilitation Center was found to not be in compliance with the Requirements for Participation in Medicare and Medicaid.

The requirement at 42 CFR, Subpart 483.90(a) is NOT MET as evidenced by:

K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 372		4/18/25

Subdivision of Building Spaces - Smoke Barrier Construction
2012 EXISTING
Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.

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Electronically Signed		04/23/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANFIELD NURSING AND REHABILITATION CENTER	509 NORTH CARRIER STREET 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 372	Continued From page 1 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.	K 372		

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure smoke barriers could restrict the transfer of smoke in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) of four (4) smoke barrier walls, staff, and 28 residents. The facility had the capacity for 60 beds with a census of 53 on the day of the survey.

The findings include:

Observation, during the building inspection tour on 04/01/2025 at 1:46 PM, revealed the smoke barrier wall located in the attic between the Administrators Office and room 35, was not accessible for inspection due to Heating, Venting, and Air Conditioning Ductwork and Sprinkler Piping blocking access in the Attic. The attic access points were located over 50 feet from the barrier walls and no visual inspection for penetrations was possible from the access locations.

Interview, with the Maintenance Director on 04/01/2025 at 1:47 PM, revealed the access point for the smoke barrier had been removed when the ceiling in that area had been redone due to a structural beam replacement.

The finding was verified by the Maintenance Director at the time of observation and the

K372
1. An attic access door was installed for the area of the Administrator□s office to access and be able to visually inspect the attic space identified as obstructed by duct work and sprinkler pipes. This was completed on 4/17/25 by the Maintenance Supervisor and the Regional Maintenance Supervisor.
2. All residents would have the potential to be affected by the alleged deficient practice. There are no additional visually obstructed attic smoke barriers that may require additional access doors as verified by the Maintenance Supervisor and the Regional Maintenance Supervisor on 4/17/25.
3. Education was provided to the maintenance staff by the Administrator regarding the regulatory intent of K372 Smoke Barriers and NFPA Standards to include smoke barriers must be accessible via access points for inspection and not obstructed by duct work, sprinkler pipes, etc., that could prohibit visual inspection. This was completed on 4/17/25.
4. Beginning 4/17/25, the Maintenance Supervisor will audit the installed attic access door and verify there has been no further construction and/or installations that would potentially impact visible

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	185329	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/01/2025

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K 372	Continued From page 2 Administrator at the exit conference on 04/01/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1-2-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). (b) Not less than two separate smoke compartments shall be provided on each floor. (2)*Smoke 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 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. 8.5.6.2 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke.	K 372	inspection 1 time weekly for 4 weeks, then biweekly for 4 weeks, then monthly for 1 month. Any identified issue will be addressed at the time of discovery. The results of the monitoring reported by the Administrator to the monthly Quality Assurance Process Improvement (QAPI) meeting for review and recommendation. The facility QAPI Committee consists of, but is not limited to, the Administrator, Director of Nursing, Infection Preventionist, Social Services, MDS, Activities Director, Dietary Manager, and the Medical Director. 5. Compliance date: 4/18/2025	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		4/18/25

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K 920	Continued From page 3 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain power strips in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect eight (8) resident rooms, staff, and 16 residents. The facility had the capacity for 60 beds with a census of 53 on the day of the survey. The findings include: 1. Observation, during the building inspection	K 920	K920 1. The identified power strips from Rooms 30, 32A, 20B, 2B, 16B, 6B, 7A, and 9B were removed on 4/17/25 by the Maintenance Supervisor and the Regional Maintenance Supervisor. 2. All residents would have the potential to be affected by the alleged deficient practice. On 4/17/25, the Maintenance Director completed facility rounding to verify no additional power strips were in use for non-PCREE items. None were	

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K 920	Continued From page 4 tour on 04/01/2025 at 2:05 PM, revealed a rated power strip, not part of an assembly, at the resident bed with a nebulizer and personal electronics plugged into it located in resident room 30. Interview, on 04/01/2025 at 2:06 PM with the Maintenance Director, revealed the facility was not aware of the power strip in the room. 2. Observation, during the building inspection tour on 04/01/2025 at 2:07 PM, revealed a rated power strip, not part of an assembly, under the resident bed with a television plugged in located in resident room 32 under bed A. Interview, on 04/01/2025 at 2:08 PM with the Maintenance Director, revealed the facility was not aware of the power strip in the room. 3. Observation, during the building inspection tour on 04/01/2025 at 2:10 PM, revealed a rated power strip, not part of an assembly, at the resident bed with personal electronics plugged in located in resident room 20 at bed B. Interview, on 04/01/2025 at 2:11 PM with the Maintenance Director, revealed the facility was not aware of the power strip in the room. 4. Observation, during the building inspection tour on 04/01/2025 at 2:33 PM, revealed a rated power strip, not part of an assembly, at the resident bed with personal electronics plugged in located in resident room 2 at bed B. Interview, on 04/01/2025 at 2:34 PM with the Maintenance Director, revealed the facility was not aware of the power strip in the room. 5. Observation, during the building inspection tour on 04/01/2025 at 2:35 PM, revealed a rated power strip, not part of an assembly, at the resident bed with personal electronics plugged in located in resident room 16 at bed B. Interview, on 04/01/2025 at 2:36 PM with the Maintenance Director, revealed the facility was not aware of the	K 920	identified. 3. Education was provided to the maintenance staff by the Administrator regarding the regulatory intent of K920 and NFPA Standards to include that power strips in resident rooms may not be used for non-PCREE items (such as personal electronics). This was completed on 4/17/25. 4. Beginning 4/17/25, the Maintenance Director or Maintenance Assistant will complete an audit of all resident rooms 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then 1 time a week for 4 weeks to ensure there are no power strips in use for non-PCREE items such as personal electronics. Any identified issue will be addressed at the time of discovery. The results of the monitoring reported by the Administrator to the monthly Quality Assurance Process Improvement (QAPI) meeting for review and recommendation. The facility QAPI Committee consists of, but is not limited to, the Administrator, Director of Nursing, Infection Preventionist, Social Services, MDS, Activities Director, Dietary Manager, and the Medical Director. 5. Compliance date: 4/18/2025	

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K 920	Continued From page 5 power strip in the room. 6. Observation, during the building inspection tour on 04/01/2025 at 2:41 PM, revealed a rated power strip, not part of an assembly, at the resident bed with personal electronics plugged in located in resident room 6 at bed B. Interview, on 04/01/2025 at 2:37 PM with the Maintenance Director, revealed the facility was not aware of the power strip in the room. 7. Observation, during the building inspection tour on 04/01/2025 at 2:43 PM, revealed a rated power strip, not part of an assembly, at the resident bed with a television plugged in located in resident room 7 at bed A. Interview, on 04/01/2025 at 2:44 PM with the Maintenance Director, revealed the facility was not aware of the power strip in the room. 8. Observation, during the building inspection tour on 04/01/2025 at 2:45 PM, revealed a rated power strip, not part of an assembly, at the resident bed with electric chair plugged in located in resident room 9 at bed B. Interview, on 04/01/2025 at 2:46 PM with the Maintenance Director, revealed the facility was not aware of the power strip in the room. The findings were verified by the Maintenance Director at the time of observation and the Administrator at the exit conference on 04/01/2025. Actual NFPA Standard: NFPA 99 Health Care Facilities Code, (2012) 10.2.3.6 Multiple Outlet Connection. Two or more power receptacles supplied by a flexible cord shall be permitted to be used to supply power to plug-connected components of a movable equipment assembly that is rack-, table-, pedestal-, or cart mounted, provided that all of the	K 920		

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K 920	Continued From page 6 following conditions are met: (1) The receptacles are permanently attached to the equipment assembly. (2)*The sum of the ampacity of all appliances connected to the outlets does not exceed 75 percent of the ampacity of the flexible cord supplying the outlets. (3) The ampacity of the flexible cord is in accordance with NFPA 70, National Electrical Code. (4)*The electrical and mechanical integrity of the assembly is regularly verified and documented.	K 920		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on	K 923		4/18/25

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K 923	Continued From page 7 each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide oxygen storage in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) oxygen storage room, staff, and 28 residents. The facility had the capacity for 60 beds with a census of 53 on the day of the survey. The findings include: Observation, during the building inspection tour on 04/01/2025 at 2:15 PM, revealed the oxygen transfilling storage room had six (6) freestanding oxygen E tanks unsecured on the floor sitting next to the oxygen tank rack. Interview, on 04/01/2025 at 2:16 PM with the Maintenance Director, revealed the facility was not aware the E tanks were on the floor beside the tank rack. The finding was verified by the Maintenance	K 923	K923 1. The identified 6 free-standing oxygen e-tanks were secured and placed in a cylinder stand on 4/1/25 by the Regional Emergency/Disaster Manager and the Maintenance assistant. 2. All residents would have the potential to be affected by the identified deficient practice. There are no additional oxygen storage areas in the facility. 3. Education was provided to the maintenance and nursing staff on the regulatory intent of K923 in conjunction with NFPA Standards, that free-standing oxygen cylinders must be properly chained or supported in a proper cylinder stand or cart. This was completed on 4/17/25. 4. Beginning 4/17/25, the Maintenance Supervisor will audit the oxygen storage room 5 times a week for 4 weeks, then 3 times a week for 8 weeks to ensure there are no unsecured oxygen tanks, and that	

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K 923	Continued From page 8 Director at the time of observation and the Administrator at the exit conference on 04/01/2025. Actual NFPA Standard: NFPA 99 Health Care Facilities Code, (2012) 11.3.2* Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3. 11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. 11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. 11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft) (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1?2 hour 11.3.2. 4 Gas cylinder and cryogenic liquid container storage shall comply with 5.1.3.5.12. 11.3.2.5 Cylinder and container storage locations shall comply with 5.1.3.3.1.7 with respect to temperature limitations. 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3. 11.6.2.3 Cylinders shall be protected from damage by means of the following specific	K 923	are all properly chained or supported in a cylinder stand. Any identified issue will be addressed at the time of discovery. The results of the monitoring reported by the Administrator to the monthly Quality Assurance Process Improvement (QAPI) meeting for review and recommendation. The facility QAPI Committee consists of, but is not limited to, the Administrator, Director of Nursing, Infection Preventionist, Social Services, MDS, Activities Director, Dietary Manager, and the Medical Director. 5. Compliance date: 4/18/2025	

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K 923	Continued From page 9 procedures: (1) Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device. (2) Oxygen cylinders shall not be stored near elevators or gangways or in locations where heavy moving objects will strike them or fall on them. (3) Cylinders shall be protected from tampering by unauthorized individuals. (4) Cylinders or cylinder valves shall not be repaired, painted, or altered. (5) Safety relief devices in valves or cylinders shall not be tampered with. (6) Valve outlets clogged with ice shall be thawed with warm - not boiling - water. (7) A torch flame shall not be permitted, under any circumstances, to come in contact with a cylinder, cylinder valve, or safety device. (8) Sparks and flame shall be kept away from cylinders. (9) Even if they are considered to be empty, cylinders shall not be used as rollers, supports, or for any purpose other than that for which the supplier intended them. (10) Large cylinders (exceeding size E) and containers larger than 45 kg (100 lb) weight shall be transported on a proper hand truck or cart complying with 11.4.3.1. (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. (12) Cylinders shall not be supported by radiators, steam pipes, or heat ducts	K 923		

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E 000	Initial Comments	E 000		

42 CFR 483.73

Type of Structure: One (1) story, (1965), Type III (211), protected ordinary construction with four (4) smoke compartments and a complete automatic dry sprinkler system.

An Emergency Preparedness Recertification Survey was conducted on 04/01/2025, in accordance with 42 Code of Federal Regulations, Subpart 483.73 (a)(3): (emergency preparedness) Requirements for Long Term Care Facilities. During this Recertification Survey, Morganfield Nursing and Rehab Center was found to be in compliance with the Requirements for Participation in Medicare and Medicaid.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/23/2025

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.