

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

PRINTED: 03/10/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/25/2014
NAME OF PROVIDER OR SUPPLIER  MCCRACKEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(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  An Abbreviated Survey investigating #KY21232 was conducted on 02/24/14 through 02/25/14 to determine the facility's compliance with Federal requirements. #KY21232 was substantiated with a deficiency cited at the highest S/S of an "A".	F 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.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>185272</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	DATE SURVEY COMPLETE:  <b>2/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MCCRACKEN NURSING AND REHABILITATION CI</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>867 MCGUIRE AVE. PADUCAH, KY</b>		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>F 203</b>	<p><b>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</b></p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure a resident's legal representative obtained a written notice of discharge as soon as practicable for one of three (3) sampled residents (Resident #1). Resident #1 was discharged from the facility, on 12/25/13, after being transferred to the hospital. The resident's legal representative did not receive a notice in writing related to the discharge.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses which included Psychosis, Depressive Disorder, Senile Dementia, Anxiety and Bipolar Disorder.</p> <p>Review of the nurse's notes, dated 12/25/13 at 12:25 PM, revealed the resident had become very agitated, trying to throw him/herself on the floor. The resident made statements of suicidal ideation. The resident was transferred to the hospital at that time.</p> <p>Further review of the record revealed there was no documented evidence of notice of discharge was given to</p>		

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The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 203	<p>Continued From Page 1 the resident or the resident's guardian.</p> <p>Interview with the Administrator, on 02/25/14 at 2:25 PM and 3:00 PM, revealed the resident had no bed hold days left when he/she was transferred to the hospital, on 12/25/13. She revealed the resident's guardian was notified by phone of the resident's discharge; however, she did not send a written notice.</p>
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