

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

PRINTED: 06/18/2014
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 06/05/2014
NAME OF PROVIDER OR SUPPLIER MCCRACKEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 887 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 281	<p>Continued From page 1</p> <p>medication on the MAR should be documented as soon as the medications were given.</p> <p>Observation of a medication pass, on 06/03/14 at 9:45 AM, revealed the following medications had been taken out of the package and placed in a medication cup, sitting in the cart:</p> <ol style="list-style-type: none"> 1. Losartan Potassium 100 mg tablet 2. Amlodipine Besylate 5 mg tablet 3. Omeprazole Delayed Release (DR) 20 mg capsule 4. Namenda XR 128 mg capsule 5. Thera-M vitamin/mineral supplement, (1) tablet <p>The medications were given to Unsampled Resident C by Registered Nurse (RN) #1 at this time. The medications were initialed as given prior to administration.</p> <p>Observation of a medication pass, on 06/03/14 at 10:10 AM, revealed the following medications had been taken out of the package and placed in a medication cup, sitting in the cart:</p> <ol style="list-style-type: none"> 1. Folic Acid 1 milligram (mg) tablet 2. Tab-A-Vite vitamin/supplement (1) tablet 3. Potassium Chloride Extended Release (ER) 10 milliequivalents (meq), (1) capsule 4. Extended phenytoin sodium 100 mg capsule 5. Acetazolamide 125 mg tablet 6. Prednisone 20 mg tablet 7. Lasix 40 mg tablet 8. Pantoprazole sodlum 40 mg tablet 9. Xanax 0.25 mg tablet, had already been signed out as given at 9:00 AM 10. Acebutolol 200 mg capsule 11. Mucinex ER 600 mg tab 12. Fish oil 1000 mg capsule 13. Citalopram 20 mg tablet 	F 281	<ol style="list-style-type: none"> 1. On 6/18/2014 The Director of Nursing reeducated RN # 1 on medication administration. An observation by the Director of Nursing was conducted on 6/25/14 with RN #1 and it was noted that all medications were not preset prior to administration and the medication administration record was initialed after the residents received their medications. 2. A medication pass was observed on each shift by the DON on, 06/11/14 and 06/12/14. No nurses were noted to open medication and place in medicine cup and place medicine cup in drawer prior to the medication administration pass. All nurses signed medication administration record after medication was given to resident. 3. All licensed nursing staff have been assigned Medication Administration education course to be completed by 06/30/2014 through Silverchair learning our electronic education system. No licensed staff will work after 06/30/2014 without having had this education. 	7/18/14

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

PRINTED: 06/18/2014
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 06/05/2014
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 281	Continued From page 2 The medications were given to Unsampled Resident D by RN #1 at this time. The medications were initialed as given prior to administration. Interview with RN #1, on 06/03/14 at 4:20 PM, revealed it was usual for her to setup medications prior to administration; however, it was not the correct procedure. Interview with the Director of Nursing (DON), on 06/05/14 at 12:40 PM, revealed she expected staff to pull what medications were to be given, compare them to the Medication Administration Record (MAR), remove the pills from the package, give the medications, and document as given afterwards. She revealed medications should not be removed from the package until the resident was available for administration.	F 281	4. The Director of Nursing/Assistant Director of Nursing/ Unit Managers will observe one med pass per shift weekly for 12 weeks to ensure medications are pulled at the time of administration and signed off after administration. Results of The results of these observations will be forward to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at any time concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, and the Social Services Director with the Medical Director attending at least quarterly.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as Isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to Infections.	F 441	1. On 6/18/2014 The Director of Nursing reeducated RN # 1 on medication administration. An observation by the Director of Nursing was conducted on 6/25/14 with RN #1 to include observation of medication administration with Resident C and D and RN #1 was noted to use alcohol gel between residents and wash hands with soap and water at least every three residents. In addition RN# 1 was not observed handling any medication with her hands.	7/18/14

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

PRINTED: 06/18/2014
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 06/05/2014
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 441	<p>Continued From page 3</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>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 appropriate handwashing and infection control practices during a medication pass for two unsampled resident (Resident C and Resident D).</p> <p>The findings include: Review of the Hand Hygiene policy/procedure, undated, revealed to use hand hygiene between resident contact.</p> <p>Observation of a medication pass, on 06/03/14 at 9:45 AM and 10:10 AM, revealed Registered Nurse (RN) #1 administered medications to</p>	F 441	<p>2. A medication pass was observed on each shift by the DON on, 06/11/14 and 06/12/14. All nurses observed using alcohol gel between each resident when passing medication and washing hands with soap and water at a minimum of every three residents. No nurses were observed handling medication with hands.</p> <p>3. All licensed staff were retrained on 6/25/2014 by the Director of Nursing or Assistant Director of Nursing on handwashing, ensuring that they use alcohol gel in between each medication pass, and that they utilize soap and water at minimal every third resident and not touching the medication with bare hands. No Licensed Staff will work after 06/30/2014 without receiving this re-education.</p> <p>4. The Director of Nursing/Assistant Director of Nursing/Unit Managers will observe one med pass per shift weekly for 12 weeks to ensure proper infection control procedures are followed including hand wash/sanitizing during medication pass. The results of these observations will be forward to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at any time concerns are identified, the Quality Assurance committee will convene to review and make further</p>	

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

PRINTED: 06/18/2014
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 06/05/2014
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 441	Continued From page 4 Resident C and Resident D without washing her hands or using hand sanitizer between residents. While preparing medication for Resident D, she removed a pill from the package into her hand before placing the pill in the medicine cup. Another pill dropped into the medicine cart, so RN #1 picked the pill up with her hand and placed it in the medicine cup. Interview with RN #1, on 06/03/14 at 4:20 PM, revealed she was supposed to use hand sanitizer between each resident while administering medications. She was not supposed to touch medication with her hand; however, it was a "bad habit." Interview with the Director of Nursing (DON), on 06/05/14 at 12:40 PM, revealed staff should use hand sanitizer between each resident while administering medications and wash their hands with soap and water after every three (3) residents. She revealed staff should not touch medications with their hands.	F 441	recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, and the Social Services Director with the Medical Director attending at least quarterly.	
F 460 SS=D	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by:	F 460	1. Cubicle curtain in Room 112 was replaced by maintenance staff on 06/05/14. 2. A 100% audit of all resident rooms was completed by Director of Maintenance on 06/06/14. All rooms were found to have cubicle curtains in place.	7/18/14

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

PRINTED: 06/18/2014
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 06/06/2014
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)	(X6) COMPLETION DATE
F 460	<p>Continued From page 5</p> <p>Based on observation, staff interviews, and review of the facility's policy it was determined the facility failed to assure full visual privacy for two (2) unsampled residents (Resident A and B) in a semi-private room.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Bill of Residents Rights", dated 07/01/2009, revealed the residents have a right to personal privacy and privacy in accommodations, medical treatment, personal care etc shall be provided.</p> <p>Observation during initial tour of the facility, on 06/03/14 at 10:05 AM, revealed there was no privacy curtains present separating residents in a semi-private room. There was not a curtain in place to to assure full visual privacy to both residents when providing care.</p> <p>Further observations were made on 06/03/14 at 2:00 PM and again on 06/04/14 at 8:00 AM, and 3:30 PM each time revealing no privacy curtains present.</p> <p>Interview, on 06/04/14 at 3:30 PM with Resident A, revealed when asked how does it make you feel when they provide care for you without using a privacy curtain he/she stated "I don't care anymore".</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 06/05/14 8:35 AM, revealed she was not aware they did not have a privacy curtain. When asked how she expected the nurse aids to provide privacy she stated " just care for them, they can shut the door but it does not protect them from seeing the other resident".</p>	F 460	<p>3. The Administrator retrained Department Heads to include nursing, social services, maintenance, laundry and housekeeping staff on ensuring that cubicle curtains are in place to provide privacy to residents in semi-private rooms with completion date of 06/30/14.</p> <p>4. Department heads will make daily rounds for (4) four weeks and then weekly rounds time (8) eights weeks to ensure all cubicle curtains are in place. The results of these rounds will be forward to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at any time concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, and the Social Services Director with the Medical Director attending at least quarterly.</p>	

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

PRINTED: 06/18/2014
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 06/05/2014
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 460	Continued From page 6 Interview with Registered Nurse (RN) #2, on 06/05/14 at 8:40 AM, revealed she was not aware the privacy curtain was down. When asked how she expected the nurse aids to provide care she stated " I don't think they could provide care unless they tried to be discreet". Interview with Director of Nursing (DON), on 06/05/14 at 12:45 PM, revealed each resident should have a privacy curtain and all rooms should have privacy curtains in place. She stated when staff was providing care and there were two residents are in the room , she expected the curtain to be pulled and the door closed.	F 460			

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

PRINTED: 06/18/2014
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2014
--	--	--	--

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
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1970.</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: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1970, and upgraded in 1999 with 35 smoke detectors and 2 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry and wet sprinkler system installed in 1970 and upgraded in 2012.</p> <p>GENERATOR: Type II generator installed in 1980. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code Survey was conducted on 06/03/14 and 06/04/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred three (103) beds with a census of eighty-six (86) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</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 and plan of correction.. In addition, preparation 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 allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to 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 ten (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 admission by the facility. The plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Maureen Dwyer* TITLE: Administrator (X6) DATE: 6/27/14

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.

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

PRINTED: 06/18/2014
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2014
--	--	--	--

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
K 000 K 025 SS=E	<p>Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).</p> <p>Deficiencies were cited with the highest deficiency identified at "E" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of five (5) smoke compartments, sixty-four (64) residents, staff and visitors. The facility has the capacity for one-hundred three (103) beds and at the time of the survey, the census was eighty-six (86).</p> <p>The findings include: Observation, on 06/03/14 at 10:50 AM with the</p>	K 000 K 025	<p>Smoke partition located at the laundry area will be extended to the roof decking. Work will be completed by Vanguard Contractors with completion scheduled for 07/18/14.</p> <p>Facility maintenance staff has completed an audit of each smoke compartment on 06/06/14 has not identified any other area in which the smoke partition does not extend to the ceiling.</p> <p>Maintenance Director reeducated by facility administrator on 06/25/14 on ensuring that all smoke compartments extend to roof decking to prevent the passage of smoke.</p> <p>Maintenance Director will inspect smoke barriers monthly for three months to ensure that they do not allow for the passage of smoke into a fire compartment. The results of these observations will be forward to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at any time concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, and the Social Services Director with the Medical Director attending at least quarterly.</p>	7/18/14

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

PRINTED: 06/18/2014
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2014
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
K 025	<p>Continued From page 2</p> <p>Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located at the laundry area did not extend to the roof decking of the facility.</p> <p>Interview, on 06/03/14 at 10:51 AM with the Maintenance Supervisor, revealed he was unaware the wall was not properly constructed to resist the passage of smoke.</p> <p>The census of eighty-six (86) was verified by the Administrator on 06/04/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 06/04/14.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p>	K 025		

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

PRINTED: 06/18/2014
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2014	
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
K 025	Continued From page 3 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect four (4) of five (5) smoke compartments, seventy-six (76) residents, staff and visitors. The facility has the capacity for one-hundred three (103) beds and at the time of the survey, the census was eighty-six (86).	K 025	Premier Fire & Sprinkler will replace sprinkler heads in the following areas: Wing 2 Central Bath; closet of Wing 3 soiled utility room; resident lounge; within six (6) feet of MDS office (2); resident bathroom of Room #20; laundry room (4); Wing 1 Central Bath (4), Wing 1 corridor by Rooms #107 & # 109; resident bathroom of room #105; Wing 1 clean linen room; Resident room #103; Resident room #100 and bathroom; Wing 1 Housekeeping closet and Dining Room (6). Completion date is scheduled for 07/18/14.	7/18/14
K 062 SS=E		K 062		

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

PRINTED: 06/18/2014
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2014
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
K 062	Continued From page 4 The findings include: Observations, on 06/03/14 at 2:59 PM with the Maintenance Supervisor, revealed one quick response and four (4) standard response sprinkler heads in the same compartment located in the Wing 2 central bath. Interview, on 06/03/14 at 3:00 PM with the Maintenance Supervisor, revealed he was unaware the one sprinkler head located in the stall was a quick response sprinkler head. Observations, on 06/03/14 at 3:10 PM with the Maintenance Supervisor, revealed a recalled me-1 sprinkler head located in the closet of the Wing 3 soiled utility room. Interview, on 06/03/14 at 3:11 PM with the Maintenance Supervisor, revealed he was unaware the one sprinkler head located in the closet was a recalled sprinkler head. Observations, on 06/03/14 at 3:15 PM with the Maintenance Supervisor, revealed a corroded sprinkler head in the Human Resources office. Interview, on 06/03/14 at 3:16 PM with the Maintenance Supervisor, revealed he was unaware of the corrosion buildup on the sprinkler head. Observations, on 06/03/14 at 3:20 PM with the Maintenance Supervisor, revealed a corroded sprinkler head in the resident lounge. Interview, on 06/03/14 at 3:21 PM with the Maintenance Supervisor, revealed he was	K 062	The Director of Maintenance completed an audit of all sprinkler heads on 06/10/14 and did not identify any additional sprinkler heads with corrosion, foreign materials or paint. The Nursing Home Administrator retrained the Director of Maintenance on 06/25/14 regarding annual inspection from the floor to identify and replace any sprinkler head that is corroded, damaged or painted or has foreign material. Maintenance Director will inspect sprinkler heads monthly for 3 months. The results of these inspections will be forward to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at any time concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, and the Social Services Director with the Medical Director attending at least quarterly.	

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

PRINTED: 06/18/2014
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2014
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
K 062	<p>Continued From page 5</p> <p>unaware of the corrosion buildup on the sprinkler head.</p> <p>Observations, on 06/03/14 at 3:23 PM with the Maintenance Supervisor, revealed two (2) sprinklers located within six (6) feet of one another in the Minimum Data Set (MDS) office.</p> <p>Interview, on 06/03/14 at 3:24 PM with the Maintenance Supervisor, revealed he was unaware the sprinkler heads were located to close together.</p> <p>Observations, on 06/03/14 at 3:30 PM with the Maintenance Supervisor, revealed a corroded sprinkler head in the resident bathroom of room #205.</p> <p>Interview, on 06/03/14 at 3:31 PM with the Maintenance Supervisor, revealed he was unaware of the corrosion buildup on the sprinkler head.</p> <p>Observations, on 06/03/14 at 3:45 PM with the Maintenance Supervisor, revealed four (4) corroded sprinkler heads in the laundry room.</p> <p>Interview, on 06/03/14 at 3:46 PM with the Maintenance Supervisor, revealed he was unaware of the corrosion buildup on the sprinkler heads.</p> <p>Observations, on 06/03/14 at 4:00 PM with the Maintenance Supervisor, revealed four (4) corroded sprinkler heads in the Wing 1 central bath.</p> <p>Interview, on 06/03/14 at 4:01 PM with the Maintenance Supervisor, revealed he was</p>	K 062		

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

PRINTED: 06/18/2014
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2014
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
K 062	<p>Continued From page 6</p> <p>unaware of the corrosion buildup on the sprinkler heads.</p> <p>Observations, on 06/03/14 at 4:05 PM with the Maintenance Supervisor, revealed a corroded sprinkler head in the corridor outside of resident rooms #107 and 109.</p> <p>Interview, on 06/03/14 at 4:06 PM with the Maintenance Supervisor, revealed he was unaware of the corrosion buildup on the sprinkler head.</p> <p>Observations, on 06/03/14 at 4:10 PM with the Maintenance Supervisor, revealed a corroded sprinkler head in the resident bathroom of room #105.</p> <p>Interview, on 06/03/14 at 4:11 PM with the Maintenance Supervisor, revealed he was unaware of the corrosion buildup on the sprinkler head.</p> <p>Observations, on 06/03/14 at 4:14 PM with the Maintenance Supervisor, revealed a corroded sprinkler head in the clean linen room on Wing 1.</p> <p>Interview, on 06/03/14 at 4:15 PM with the Maintenance Supervisor, revealed he was unaware of the corrosion buildup on the sprinkler head.</p> <p>Observations, on 06/03/14 at 4:20 PM with the Maintenance Supervisor, revealed a corroded sprinkler head in the resident room #103.</p> <p>Interview, on 06/03/14 at 4:21 PM with the Maintenance Supervisor, revealed he was unaware of the corrosion buildup on the sprinkler</p>	K 062		

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

PRINTED: 06/18/2014
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2014
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
K 062	<p>Continued From page 7 head.</p> <p>Observations, on 06/03/14 at 4:23 PM with the Maintenance Supervisor, revealed a corroded sprinkler head in the resident room #100 and in the bathroom the sprinkler head was painted.</p> <p>Interview, on 06/03/14 at 4:24 PM with the Maintenance Supervisor, revealed he was unaware of the corrosion buildup on the sprinkler head and the paint on the one in the bathroom.</p> <p>Observations, on 06/03/14 at 4:27 PM with the Maintenance Supervisor, revealed a corroded sprinkler head in the housekeeping closet on Wing 1.</p> <p>Interview, on 06/03/14 at 4:28 PM with the Maintenance Supervisor, revealed he was unaware of the corrosion buildup on the sprinkler head</p> <p>Observations, on 06/03/14 at 4:30 PM with the Maintenance Supervisor, revealed six (6) corroded sprinkler heads in the dining room.</p> <p>Interview, on 06/03/14 at 4:31 PM with the Maintenance Supervisor, revealed he was unaware of the corrosion buildup on the sprinkler heads.</p> <p>The census of eighty-six (86) was verified by the Administrator on 06/04/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 06/04/14.</p> <p>Actual NFPA Standard:</p>	K 062		

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

PRINTED: 06/18/2014
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 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/04/2014
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	
K 062	Continued From page 8 Reference: NFPA 25 (1998 Edition). 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062			