

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

PRINTED: 03/06/2013  
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 03/01/2013
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NAME OF PROVIDER OR SUPPLIER  MCCRACKEN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001
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F 000	INITIAL COMMENTS	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 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.	
F 281 SS=D	<p>An abbreviated survey (KY #19801) was conducted on 02/22/13 through 03/01/13 to determine the facility's compliance with Federal requirements. KY #19801 was substantiated with regulatory violations identified.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</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 interviews, record reviews and review of the facility policy and procedure, it was determined, the facility failed to ensure professional standards were met for one resident' (#1.) in the select sample of three residents, regarding the resident's decline and a physician's order to send to the hospital, on 01/27/13 at 6:30 PM, that was not carried out until the resident coded and the paramedics were called at 7:21 PM.</p> <p>Findings include:</p> <p>An interview with the Administrator, on 03/01/13 at 10:52 AM, revealed the facility did not have a specific policy for the standard of following a physician's order and stated the facility utilizes the Lippincott Manual, as a guide for the administration of nursing skills. A review of the Lippincott Manual of Nursing Practice, Ninth Edition, Common legal claims for Departure from</p>	F 281	<p>1. On 1/27/2013, the identified resident was sent to the emergency room as ordered by the physician.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marilyn Doyen TITLE: Administrator (X6) DATE: 3/15/13

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 281	<p>Continued From page 1</p> <p>Standards of Care, Box 2-3, on page #17, revealed the failure to implement a physician's, Advance Practice Registered Nurse's, or a physician's assistant's order properly or in a timely fashion, was one of the most common legal claims made against professional nurses. Standard of Practice #10 stated "a deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurses decision, actions and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because the passage of time may lead to a less than accurate recollection of the specific events.</p> <p>An interview with the physician, on 02/27/13 at 11:27 AM, revealed the physician stated "it would be common sense," to expect when a physician gives an order to send a resident to the hospital, that the staff would carry this out. However, "in retrospect," the physician stated there was a terminal event unfolding, as the day progressed and he was unable to state if immediate transport would have made a difference, in the resident's death.</p> <p>A record review revealed Resident #1 was admitted on 12/17/09 and readmitted on 07/01/12, with diagnoses to include Psychosis; Schizoaffective Disease; Seizure Disorder; Diabetes; Panic Disorder with Agoraphobia; Parkinson's Disease; A History Abdominal Pain and Colon Resection, Chronic Obstructive Pulmonary Disease, Chronic Heart Failure and was a Full Code. A review of the quarterly Minimum Data Set (MDS,) dated 12/06/12, revealed the facility assessed the resident as</p>	F 281	<p>2. On 02/20/2013, an audit on all current residents that had been transferred to the hospital or emergency room in the past thirty (30) days to identify concerns with timely transfer and notification of the physician if staff were unable to carry out the order for transfer. No concerns were identified during the audit. This audit was completed by the Regional Nursa Consultant.</p> <p>3. All licensed nurses were re-educated on 02/15/2013 by the Assistant Director of Nursing ensuring that physician orders are followed in a timely manner end if unable to complete the physician orders the physician must be notified immediately. No licensed nurses worked past 3-14-2013 without having receiving this re-education.</p> <p>4. The Assistant Director of Nursing and/or Unit Managers will review any physician orders, daily Monday through Friday for four (4) weeks, then weekly for eight (8) weeks to ensure that the professional standard are being met and physician orders are being followed in a timely manner or the physician is contacted if the nurse is unable to follow the physician orders. The results of these audits will be forward to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance committee will convene</p>		

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F 281	<p>Continued From page 2</p> <p>independently cognitively intact with a Basic Intellectual Mental Score (BIMS) of 15. A review of the "Respiratory: Plan of Care," dated 02/09/12, revealed the staff were to report any adventitious breath sounds to the physician, check the resident's vital signs, as ordered and as needed (PRN,) and monitor for cyanosis, shortness of breath, a change in the level of consciousness and to update the physician/ family, as needed.</p> <p>An interview with CNA #1, on 02/26/13 at 3:22 PM, revealed the resident had been weak and "kind of out of it," the week before, but stated on this Sunday, 01/27/13 she had to have help rolling the resident over in bed and to assist with changing the brief. The resident would not feed him/herself and would not eat but a few bites when the staff tried to encourage this. The CNA had reported this to Licensed Practical Nurse (LPN) #1, "about 5:00 AM," that the resident was weaker that morning and the resident's vital signs were taken. Sometime that morning, the change in the resident was reported to the physician. LPN #1 told the CNA the resident was possibly coming down with Pneumonia or Influenza, that was going around the building.</p> <p>An interview with LPN #1, on 02/25/13 at 4:15 PM, revealed she had worked 6:00 AM until 6:00 PM, the week-end of 01/26-27/13. On Saturday, 01/26/13, the resident had complained of nausea and needed to have a bowel movement. A laxative was given with good results. On Sunday, he/she complained of "feeling sick to his/her stomach" and the staff kept trying to encourage liquids. The physician was called at approximately 11:00 AM and the staff were to</p>	F 281	<p>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>	3/15/13

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F 281	<p>Continued From page 3</p> <p>monitor and encourage liquids. Sometime during the afternoon the resident became restless and agitated. The heart rate increased "into the 140's and 150's," beats per minute. The resident's Oxygen (O2) saturation was 93-94 percent (%) on room air and at that point, Resident #1 would not allow the blood pressure (B/P) to be taken. The physician was called at approximately 6:30 PM, by LPN #2, who was the 6:00 PM until 6:00 AM nurse and an order was received to send the resident to the Emergency Room. The resident "calmed down" and his/her heart rate dropped back down to 72-76 beats per minute and "appeared to be in no distress."</p> <p>An interview with LPN #2, on 02/25/13 at 5:27 PM, revealed she had made the second call of the day, to the physician, regarding Resident #1, on 01/27/13 at 6:30 PM and informed the physician the resident's heart rate was elevated at 150-152 beats per minute and the order was given to send the resident out. LPN #2 stated she had gone back into Resident #1's room at approximately 6:45 PM and the resident was calmer and the heart rate had dropped back to 68-70 beats per minute. "At that time, the the resident's condition did not seem emergent," or an emergency situation and the LPN proceeded to compile the necessary paperwork and called the on-call Nurse Administrator. The Nurse Administrator was informed of the resident's heart rate and the order to send to the ER. The Nurse Administrator stated she would call the Director of Nurses.</p> <p>An interview with the week-end, on-call Nurse Administrator, Registered Nurse (RN) #1, on 02/26/13 at 9:17 AM, revealed she had received a</p>	F 281			

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F 281	<p>Continued From page 4</p> <p>call regarding Resident #1 and the order to send to the ER, at approximately 6:35 PM, on 01/27/13. She stated she was not familiar with this resident but felt the DON was and called the DON to inform of the order. RN #1 stated this was the first she knew of the resident having been ill and stated she was not aware the physician had been called earlier in the day regarding his/her condition. RN #1 stated the DON told her not to send the resident out, just to "monitor" the resident. RN #1 decided to go to the facility; and assess the resident and called the facility and stated she was on her way and if the resident became worse before she got there, to send him/her out.</p> <p>An interview with LPN #1, on 02/25/13 at 5:05 PM, who answered the call from the Nurse Administrator/ RN #1 revealed the LPN "assumed" RN #1 was aware of the order to send the resident to the hospital, as LPN #2 had left the RN a message. LPN #1 explained the general policy of the facility, if there was not an emergency situation when the physician order was given to send to the ER, the nurses will call the ambulance company, so they can triage the call with more emergent situations, instead of calling 911. If the LPNs felt the resident was "acute enough," they would have called 911. The resident's heart rate had slowed down and he/she was resting without distress. However, interviews with both LPN #1 and #2 revealed they did not call the ambulance company or 911 until 7:21 PM.</p> <p>An interview with the DON, on 02/25/13 at 4:10 PM, revealed the staff were not to call her with an emergent situation. They were to call 911 and send the resident out. The staff were to call her</p>	F 281		

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F 281	<p>Continued From page 5</p> <p>only for advice or questions and she would walk them through the process of the (SBAR,) the Situation, Background, Assessment and Request Tool utilized by the facility, prior to calling the physician, as part of the Interact Process to decrease unnecessary hospital admissions. The DON stated she was not made aware the physician had already been called and the SBAR process had already been attempted and stated she never said not to send the resident out. If she had been made aware of an order to send the resident out and had been made aware of all the situation, she would have told them to send the resident out and not told them to start the SBAR process again.</p> <p>An interview with RN #1, on 02/26/13 at 9:35 AM, revealed it took approximately 30 minutes for the nurse to arrive at the facility. When the RN arrived in Resident #1's room the resident had his/her eyes closed and respirations were shallow "but not particularly labored." The nurse spoke to Resident #1, and the resident did not respond. He/she ws pale but not clammy. When the resident did not respond to a sternal rub the nurses told the staff to call 911. The residents breaths became "agonal, as if taking air in but not getting any air" and then the breathing and the pulse stopped and CPR was started. EMS arrived within five minutes and took over the code and the resident was transported to the hospital, where he/she expired at 8:00 PM.</p>	F 281		