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

PRINTED: 05/22/2014
FORM APPROVED
OMB NO. 0938-0391

RECEIVED MAY 2014 OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185312		C 05/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PADUCAH CENTER	501 NORTH THIRD STREET 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	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Paducah Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
	An Abbreviated Survey investigating KY #21666 was conducted 05/07/14 through 05/08/14 to detemine the facility's compliance with Federal requirements. KY #21666 was substantiated with a deficincy cited at a Scope and Severity of a "D".			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157	**F 157** Resident #1's physician confirmed he was notified of the fall via fax on 4/6/14 to the Director of Nursing.	5/19/14
	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).		On May 19, 2014, the Director of Nursing audited the event log and 24-hour report for all residents who had falls with injury during the last 60 days to validate timely physician notification. No other residents were identified.	
	The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.			
	The facility must record and periodically update the address and phone number of the resident's			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/22/14

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.

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of the facility's policies and procedures, it was determined the facility failed to immediately consult with the resident's physician when one (1) of six (6) residents (Resident #1) sustained a fall that resulted in a raised area to the back of the head measuring 6.0 centimeters (cms) and a 4.0 cm area to the right forehead. The Licensed Nurse faxed the resident's physician instead of calling the physician per the facility's policy. In addition, the Licensed Nurse failed to consult with Resident #1's physician when the resident began complaining of pain to the left side and back approximately twelve (12) hours after the fall. The findings include: Review of the facility's policy and procedure titled, "Accidents/Incidents", dated 01/08, revealed "An incident or accident is an unexpected occurrence without intention or design, or taking place not in the usual course of things or events-including but no limited to falls." The Licensed Nurse was to notify the physician and administrative staff as needed and if necessary, transfer the injured resident to the emergency room. Review of the facility's policy and procedure, titled "Change of Condition of a Resident", dated 01/08, revealed "The primary mode of urgent communication is by telephone. Other media such as fax, beeper, email, etc. may be utilized as a secondary method only after initial contact	F 157	The Assistant Director of Nursing re-educated all licensed nurses beginning on May 10, 2014 and completed on May 19, 2014 regarding timely notification per guidelines regarding the use of the primary mode of notification for the nurse to make a phone call instead of fax the physician/NP upon discovery of resident who had fallen and sustained injury. The DON, Assistant Director of Nursing or Unit Manager will audit the 24- hour report and event log for change in condition/falls to validate the physician was notified timely. This audit will be completed at least daily including weekends for 2 weeks then 5 times per week for 30 days then no less than 3 times per week for 60 additional days. Corrective action and/or re-education will be provided at point of discovery. Director of Nursing will report findings to QAPI committee and additional audits will be determined by the committee.	

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F 157	Continued From page 2 and agreement with the physician. If unable to reach either the attending physician or the medical director, the resident will be transported immediately via 911 and the Director of Nursing Services (DNS) will be notified." Record review revealed the facility admitted Resident #1 on 11/02/13 with diagnoses which included Hypertension, Migraines, Chronic Pain, Anxiety, Depression, Cardiac Pacemaker, Dementia, Chronic Kidney Disease, Hypothyroidism, Anemia, Transient Cerebral Ischemia, Symbolic Dysfunction and Psychosis. Review of Resident #1's "Change of Condition Form", dated 04/06/14 at 5:45 AM, revealed Resident #1 came out of his/her room and stated he/she had fallen. Licensed Practical Nurse (LPN) #1 assessed the resident and he/she was found to have a raised area to the back of the head measuring 6.0 centimeters (cms) and a 4.0 cm area to the right forehead. At 7:05 AM, a message was left on Resident #1's son phone; however, the physician was faxed regarding the incident rather than being called. Review of Nursing Notes, dated 04/06/14 at 6:00 PM, revealed Resident #1 complained of pain in the left side and back but there was no documented evidence the physician was notified. Interview with LPN #1, on 05/07/14 at 3:20 PM, revealed she was working on 04/06/14 when the incident occurred. She stated Resident #1 came out of his/her room and stated he/she needed a nurse because he/she had fallen. Upon assessment of the resident, LPN #1 stated the resident had busted his/her head open but did not require sutures and was not sent to the hospital.	F 157		

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F 157	Continued From page 3 Additionally, she stated she faxed the physician regarding the incident. When asked why the physician would not have sent the resident to the hospital if his/her head was busted open and there was a knot on the back of the resident's head and forehead, she stated she did not call the physician, but faxed him instead. Interview with the Assistant Director of Nursing (ADON), on 05/08/14 at 11:58 AM, revealed his expectation was for nursing staff to call the physician first, but if there was an emergency, then he would expect them to send the resident out for evaluation and then notify the physician. Interview with the Director of Nursing (DON), on 05/08/14 at 11:16 AM, revealed he would have expected LPN #1 to have called the primary care physician initially rather than faxing. Additionally, he stated LPN #2 should have notified the physician of the pain Resident #1 was having in his/her back and side after the fall. Interview with the Administrator, on 05/08/14 at 11:52 AM, revealed her expectation of the nursing staff would have been to perform an assessment of a resident who had fallen and if the resident was not showing any signs of injury, then nursing staff should monitor the resident. Additionally, she would have expected nursing staff to notify the physician per the physician's preferred method of communication. Interview with the Medical Director, on 05/08/14 at 2:07 PM, revealed his preferred method of communication was through a phone call but it was acceptable for staff to fax him.	F 157		