

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

PRINTED: 09/17/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/15/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 KENTUCKY AVENUE PADUCAH, KY 42003
--	--

(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 annual survey was conducted on 09/14/10 through 09/15/10 to determine the facility's compliance with Federal certification requirements. It was determined the facility failed to meet Federal requirements for recertification with deficiencies at the highest Scope & Severity of a "D".	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to ensure services provided or arranged by the facility met professional standards of quality for one resident (#3) in the selected sample of eight residents, related to the failure to follow written physician orders for a laboratory (lab) specimen and to complete an incident report. Findings include:  Resident #3 was admitted to the facility 09/09/10 with diagnoses to include Congestive Heart Failure, Plural Effusion, and Chronic Kidney Disease.  A review of Resident #3's physician orders, dated 09/09/10 at 2:40 PM, revealed an order for a basic metabolic panel (BMP) lab test to be obtained the following morning. A review of Resident #3's physician orders, dated 09/10/10 at 7:45 AM, revealed an order for a stat BMP with results to be called to the physician and an order for an incident report to be completed regarding	F 281	Resident #3 was the only resident to have been found affected by the deficient process. Upon the physician finding of the missed lab at 0745 on 9/10/10 (ordered 9/09/10 for BMP in am of 9/10/10) the BMP was drawn STAT @ 0823 on 9/10/10.  Physician order for an incident report to be completed on 09/10/10 was found deficient. Lack of designation of the task to complete incident report resulted in failure to complete. Upon awareness (9/15/10) by the TCU Director that the incident report had not been completed, the TCU Director assigned the completion of the incident report on 9/15/10 to the nurse caring for the patient on 9/10/10. Both nurses verbally counseled on clear communication, delegation, and hand-off.  All residents of the facility have the potential of being affected by the same deficient practice. On 9/22/10 the TCU Director completed a random audit on current residents to assure accuracy of the admission resident lab order. The audit revealed that there were no missed labs other than the one identified on resident #3 at the time of survey.	October 1, 2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Polly Bechtold RN / MSN / MHA</i>	TITLE <i>VP Nursing / Administrator</i>	(X6) DATE <i>9/29/10</i>
---	--	-----------------------------

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: 09/17/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/15/2010
NAME OF PROVIDER OR SUPPLIER  WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 KENTUCKY AVENUE PADUCAH, KY 42003		
(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>the cancellation of the BMP ordered on 09/09/10.</p> <p>An interview with Health Unit Coordinator (HUC) #1, on 09/15/10 at 10:20 AM, revealed when a resident arrived to the facility from the acute care side of the hospital, the admission orders were transcribed from the discharge orders from the hospital. If the resident had an active order for lab tests from the acute care side of the hospital and the same lab tests were then entered into the system for the long term care facility. This caused the computer to automatically discontinue the order for the long term setting as the program recognized the order as a duplicate order for lab tests. When the program ran a check later in the day for the acute care side of the hospital, the resident would then be noted as discharged and the program would subsequently discontinue all active orders on the resident. The HUC revealed the staff entering the order into the computer would first have to cancel any active orders for lab tests from the acute care side of the hospital, prior to entering the order for lab tests in the facility. This was the only way to prevent the program from ultimately cancelling the ordered lab tests.</p> <p>An interview with the Lab Information System (LIS) personnel, on 09/15/10 at 10:55 AM, revealed Resident #3's order for the BMP was cancelled in the system at 3:15 PM, when the facility entered the order into the system and the system recognized the order as a duplicate order. When the program ran a check at 5:38 PM, Resident #3 was listed as discharged from the acute care side of the hospital. The program cancelled the active order for the BMP, which had been ordered initially on the acute care side of the hospital. The LIS stated the facility identified this</p>	F 281	<p>9/21/10 a meeting was held to investigate the admission lab order deficiency. The stakeholders included the TCU Director, lab manager, CIT coordinator, and the CNO.</p> <p>POC includes:</p> <ol style="list-style-type: none"> <li>1) Revision to policy P8.6 TCU Physician's Order for Lab.</li> <li>2) Use of TCU Admission Checklist which includes admission order responsibilities.</li> </ol> <p>POC for systemic change included a change in TCU admission lab policy P8.6-TCU Physician's Order for Lab. All staff to be in-serviced on change.</p> <p>The TCU Admission Checklist will be instituted on every patient after in-servicing staff. Four action items relating to orders upon admission will be initiated when completed.</p> <p>The facility plans to monitor its performance to ensure the solution was sustainable by completion of weekly audits x4 (October 1-October 31, 2010) followed by random quarterly audits. The TCU director and lab manager will audit for one year. The quarterly audits will be submitted to the Quality Committee and an action plan will be initiated as indicated.</p>		

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

PRINTED: 09/17/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/15/2010
NAME OF PROVIDER OR SUPPLIER  WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 KENTUCKY AVENUE PADUCAH, KY 42003		
(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 2</p> <p>as a problem in May 2007. It was determined in order to avoid the program cancelling scheduled lab tests, the HUCs on the unit would first have to discontinue all lab orders from the acute side of the hospital, prior to entering the order for the long term care setting.</p> <p>An interview with HUC #2, on 09/15/10 at 2:00 PM, who had transcribed Resident #3's physician orders on 09/09/10, revealed she was aware when a resident came to the facility from the acute care side of the hospital, she needed to cancel any impending lab tests for the resident, prior to entering the order for the facility. HUC #2 revealed she was unaware Resident #3 had not had the BMP obtained initially as ordered on 09/09/10. She stated no one had discussed the issue with her and she was unaware she had failed to cancel the order, prior to re-entering the order.</p> <p>An interview with Registered Nurse (RN) #1, on 09/15/10 at 2:35 PM, revealed she was present on 09/10/10 when the physician came to the unit to review Resident #3's lab values. RN #1 stated the physician was upset the lab had not been obtained as ordered. The physician wrote an order for the stat BMP at that time, along with an order to complete an incident report regarding the lab tests being cancelled. She stated neither she nor the charge nurse, who was present on 09/10/10, completed the incident report as ordered. She had no explanation as to why the report had not been completed as ordered.</p> <p>An interview with the Director of Nursing (DON), on 09/15/10 at 2:40 PM, revealed she was unaware of the failure to obtain the lab tests or the failure to complete an incident report as</p>	F 281			

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

PRINTED: 09/17/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/15/2010	
NAME OF PROVIDER OR SUPPLIER  WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 KENTUCKY AVENUE PADUCAH, KY 42003		
(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 3</p> <p>ordered until 09/15/10. The DON revealed she had instructed RN #1 to complete an incident report earlier on 09/15/10. The DON stated she expected the staff to follow all physician orders and an incident report should have been completed on 09/10/10 when the order was written. She stated if the report had been completed as ordered, she would have reviewed the report, forwarded the report to risk management, and investigated to determine why the lab tests had not been obtained as ordered.</p> <p>An interview with RN #2/Charge Nurse, on 09/15/10 at 3:20 PM, revealed she had been the charge nurse present on 09/10/10, when the physician wrote the order for the stat lab tests and for an incident report to be completed. RN #2 revealed she should have completed an incident report as ordered, but knew the problem was the HUC failed to cancel the impending lab order from the acute side of the hospital, prior to entering the order for the lab tests when the resident entered the facility. RN #2 stated, "I take full responsibility for not completing the incident report. I should have completed the report as ordered."</p> <p>A review of the facility policy entitled Physician Orders for Lab, dated 08/20/08, revealed the policy statement of all physician orders for lab would be carried out, unless indicated by an advanced directive.</p> <p>A review of the facility policy entitled Incident Reporting: Patient, Visitor, and Auxiliaries, dated February 1990, revealed the purpose was to provide an internal notification process designed for timely reporting of information to Risk Management for purposes of tracking and</p>	F 281		

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

PRINTED: 09/17/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185416</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/15/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2501 KENTUCKY AVENUE PADUCAH, KY 42003</b>		
(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 4 trending. The risk report was used to, among other things, identify safety-related problems in the environment, equipment, and work practices.	F 281			

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

PRINTED: 09/17/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185416</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - WING A, FLOOR 3</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/14/2010</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2501 KENTUCKY AVENUE PADUCAH, KY 42003</b>
---	--

(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><b>INITIAL COMMENTS</b></p> <p>A Life Safety Code survey was initiated and conducted on 09/14/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.</p>	K 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.