

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

PRINTED: 06/14/2013  
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  05/31/2013
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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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(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		
F 281 SS=D	<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 observation, interview, record review, and facility policy review, it was determined the facility failed to ensure physician orders were followed for one (1) of sixteen (16) sampled residents (Resident #6). The facility failed to discontinue an order for Tegretol for Resident #6 when the physician wrote a new order to increase the dosage.</p> <p>Findings include:</p> <p>Interview with the Director of Nursing (DON), on 05/31/13 at 2:00 PM, revealed there was no specific policy available related to following physician's orders.</p> <p>Record review revealed the facility admitted Resident #6 on 4/19/13 with diagnoses which included Dementia w/Behavior and Epilepsy. A review of the admission Minimum Data Set</p>	F 281	<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

*Marilyn Dora*

TITLE  
NHA

(X6) DATE  
6/21/13

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>(MDS) assessment, dated 04/29/13, revealed the facility assessed Resident #6's cognition status as cognitively intact.</p> <p>A review of a physician's order, dated 04/29/13, revealed staff should administer Tegretol 200 milligrams (mg.) at bedtime every day for mood stabilization.</p> <p>Further review of the physician's orders, revealed on 05/28/13, the physician increased the Tegretol to 200 mg. two times a day.</p> <p>However, further review of the May 2013 MAR revealed the original Tegretol order for 200 mg at bedtime was not discontinued and the new order for Tegretol 200 mg. two times a day was added to the MAR. According to the boxes initiated by staff the Tegretol 200 mg was initiated as given on both orders on 05/30/13.</p> <p>Interview with Registered Nurse (RN) #8, on 05/31/13 at 10:35 AM, revealed when the physician order was taken off, the previous order should have been discontinued. RN #8 further stated according to the MAR, Resident #6 had received both doses of Tegretol.</p> <p>Interview with RN #9, on 05/31/13 at 12:50 PM, revealed the unit nurse is responsible for reviewing the physician's orders with the MAR to ensure the order was transcribed correctly daily Monday through Friday and on Monday following a weekend.</p> <p>Interview with the DON, on 05/31/13 at 9:25 AM, revealed the order for Tegretol at bedtime was not discontinued when the new order for Tegretol two</p>	F 281	<ol style="list-style-type: none"> <li>The order for Tegretol 200 mg at HS for resident # 6 was discontinued from the MAR as noted by the Director of Nursing on 5/31/2013. The Director of Nursing noted on 6/1/2013 that staff were giving and initialing Tegretol 200 mg BID as ordered.</li> <li>On 6/19/2013, an audit was conducted by the Director of Nursing, Assistant Director of Nursing and Unit Managers on all current residents' orders written in last thirty (30) days to ensure that all physicians' orders were transcribed correctly and followed. Any identified as not being correct or not followed had MD notification and correction.</li> <li>All licensed nurses were re-educated on 6/20/2013 by the Director of Nursing on ensuring that the physician orders are transcribed correctly and followed.</li> <li>The Director of Nursing, Assistant Director of Nursing and/or Unit Managers will review all orders daily Monday through Friday for two (2) weeks, then weekly for ten (10) weeks to ensure that all physicians' orders are being followed and transcribed correctly. 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 to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator,</li> </ol>	

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F 281  F 282 SS=D	<p>Continued From page 2 time a day was received. The DON stated the order should have been changed when the new order was received and the initials on the MAR indicated Resident #6 received both doses.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility policy review, it was determined the facility failed to provide care for two (2) residents (#6 and #10), in the selected sample of sixteen (16) residents. The facility failed to ensure Resident 6's bed was in the low position and failed to ensure Resident #10's head of the bed was up at a forty-five (45) degree angle. In addition, the facility failed to provide pain medication per care plan for Resident #10. Resident #10 was stating "I hurt, I hurt" and his/her eyes had excessive fluid throughout a skin assessment, incontinent care and wound care.</p> <p>Findings include: A review of the facility's policy entitled "Resident Comprehensive Care Plan", dated 09/08, revealed the resident's comprehensive care plan should be viewed as an interdisciplinary approach to managing the acute and chronic needs of the</p>	F 281  F 282	<p>Director of Nursing, Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p> <ol style="list-style-type: none"> <li>1. Resident # 10 no longer receives tube feedings, the intervention to keep the HOB elevated at a 45 degree angle was discontinued on 5/31/2013. An observation by the Director of Nursing on 6/1/2013 noted that during wound care and incontinence care that the plan of care was being followed with no complaints of pain. An observation by the Director of Nursing on 6/1/2013 noted that resident # 6's bed was in the low position per the plan of care.</li> <li>2. On 6/20/2013, the Director of Nursing, the Assistant Director of Nursing and the Unit Managers conducted an audit on all current residents' care plans to ensure that all interventions were appropriate and in place. Any identified as not being appropriate or not in place had either a care plan revision or the intervention was put in place.</li> <li>3. All nursing staff were re-educated on 5/20/2013 on ensuring that care plans are being followed and updated to ensure that services being provided or arranged by the facility in accordance with each resident's written plan of care.</li> <li>4. The Director of Nursing, the Assistant Director of Nursing and/or Unit Managers will review five (5) resident records per week and conduct observations on those five (5) residents weekly for twelve (12) weeks to ensure that plans of care are being followed. The results of</li> </ol>	

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F 282	<p>Continued From page 3 resident living in the facility.</p> <p>1. Record Review revealed Resident #6 was admitted to the facility on 4/18/11 with diagnoses to include Vascular Dementia w/Delusion and Peripheral Vascular Disease, and Chronic Kidney Disease.</p> <p>A review of the Certified Nurse Aide (CNA) Care Plan, dated 02/14/13 and the Comprehensive Care Plan for risk for injury related to falls and risk of complication related to enabler use, dated 03/14/13, revealed Resident #6 should be on a low bed.</p> <p>A review of the admission Minimum Data Set (MDS) assessment, dated 4/29/13 revealed the facility assessed Resident #6's cognition as cognitively intact and the resident had no falls.</p> <p>Observations on 05/29/13 at 9:50 AM and 4:00 PM revealed Resident #6's was in the bed but the bed was not in the lowest position.</p> <p>Interview with CNA #11, on 05/29/13 at 4:18 PM, revealed Resident #6's bed was not in the lowest position and it was supposed to be in the low position because the resident was at risk for falls. The CNA proceeded to lower the bed to the lowest position.</p> <p>Further observation on 05/31/13 at 8:40 AM revealed Resident #6 was in the bed but was not in the lowest position.</p> <p>Interview with CNA #7, on 05/31/13 at 8:40 AM, revealed Resident #6's bed should have been in</p>	F 282	<p>these audits 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>	

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F 282	<p>Continued From page 4</p> <p>the lowest position. The CNA proceeded to lower the bed.</p> <p>2. Record review revealed Resident #10 was admitted to the facility on 07/21/08 with diagnoses to include Chronic Airway Obstruction, Late effects Hemiplegia, Dysphagia, amputation Bilateral legs, Gastromy, Depression, Anxiety, Dementia, and Morbid Obesity. A review of the quarterly MDS assessment, dated 4/16/13, revealed the facility assessed Resident #10's cognition as moderately impaired and has a gastrostomy. In addition, the facility assessed Resident #10 as having frequent pain which made it difficult to sleep and the resident rates the pain as a "9" on a scale of 1-10.</p> <p>A review of the Comprehensive Care Plan for alteration in fluid balance, dated 01/25/13, and CNA care plan, dated 03/29/13, revealed an intervention to ensure the head of the bed was elevated to forty-five (45) degrees.</p> <p>Observation on 05/29/13 at 9:15 AM, 12:30 PM, 2:05 PM, and 4:00 PM and 05/30/13 at 11:15 AM revealed Resident #10 was in bed and the head of the bed was at 30 degrees and not up at forty-five (45) degrees per the care plan.</p> <p>Interview with LPN #8, on 05/29/13 at 4:35 PM, revealed Resident #10's care plan states for the head of the bed to be up forty-five (45) degrees.</p> <p>3. A review of the facility's policy entitled "Pain Management Process", not dated, revealed the facility should react to the resident's pain control needs based on the resident's goals for pain relief and the resident's goal for functional ability. The</p>	F 282		

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F 282	<p>Continued From page 5</p> <p>facility's goal should ensure all residents receive appropriate pain relief measures to assure the residents pain does not affect their ability to function within their designated goals for functional ability. The resident's care plan should be generated from the data collected from the pain assessment and updated with any changes made to the resident pain regime or residents goals.</p> <p>Further review of Resident #10's Comprehensive Care Plan for risk for impaired skin integrity related to pain, dated 01/02/13, revealed an intervention if Resident #10 complained of pain during treatment, to stop the treatment, leave safe, seek pain relief and return to complete treatment when pain was reported as acceptable.</p> <p>Observation of a skin assessment, incontinent care and wound care, conducted by Licensed Practical Nurse (LPN) #8 and CNA #10, on 05/30/13 at 9:20 AM, revealed Resident #10 was stating "I hurt, I hurt, I hurt" and had excessive liquid in his/her eyes the whole time the LPN and CNA conducted the skin assessment, and provided incontinent care and wound care to the coccyx. LPN #8 stated "I will get you something in a minute" to the resident. The LPN did not administer pain medication until the care was completed at 9:45 AM.</p> <p>Interview with LPN #8, on 05/29/13 at 4:35 PM, revealed Resident #10 was complaining of pain during the assessment and she should have administered a pain pill immediately.</p> <p>Interview with RN #8, on 05/31/13 at 10:35 AM, revealed she expected the care plans to be</p>	F 282			

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F 282	Continued From page 6 followed.  Interview with the Director of Nursing (DON), on 05/31/13 at 9:25 AM, revealed she expected the care plans to be followed. The DON stated if the care plan stated the bed should be in the low position, she expected the bed to be in the low position, if a resident is supposed to have the head of the bed up forty-five (45) degrees, she expected it to be up; if the care plan stated the resident should receive pain medication upon complaint of pain, she expected the care plan to be followed for the residents.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of Lippincott's textbook for Nursing Assistants it was determined the facility failed to provide a safe environment for one (1) resident (#11), in the selected sample of sixteen (16) residents. The facility failed to provide Oxygen (O2) in use signs, outside the resident's room or outside the therapy room, where the resident received physical therapy.	F 323	<ol style="list-style-type: none"> <li>1. On 5/31/2013, Oxygen (O2) signs were placed outside the therapy room and resident #11 room as observed by Director of Nursing.</li> <li>2. On 5/31/2013, an audit was conducted by the Assistant Director of Nursing and the Unit Managers to ensure that all resident's receiving oxygen had (O2) signs outside their rooms.</li> <li>3. On 6/20/2013, all nursing staff were re-educated on ensuring that all residents receiving oxygen have (O2) signs placed outside of each door. A no smoking sign will be attached to each supply concentrator for staff to apply when initiating oxygen. (what do you think)</li> <li>4. The Director of Nursing, the Assistant Director of Nursing and/or the Unit Managers will conduct and audit on all residents receiving oxygen daily Monday through Friday for four (4) weeks and then weekly for eight (8) weeks to ensure that all residents receiving oxygen have an (O2) sign placed outside their door. The results of these audits will be forward to the Quality Assurance Committee</li> </ol>	

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F 323	<p>Continued From page 7</p> <p>Findings include:</p> <p>Interview with the Director of Nursing, on 05/31/13 at 2:00 PM, revealed the facility uses Lippincott's Textbook for Nursing Assistants, copyright 2005, as the basis for their policy on O2 administration. A review of the textbook on page 157, Figure 9-12 revealed "oxygen in use" signs should be posted to warn patients and visitors that extra precautions are needed when oxygen therapy was in use.</p> <p>A record review revealed Resident #11 was admitted to the facility, on 5/22/13, with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD) and a physician order for O2, to have been administered at two (2) liters per minute, per nasal canula.</p> <p>An interview with Resident # 11, on 5/30/13 at 2:30 PM, revealed the resident utilized O2, "most of the time."</p> <p>An observation of Resident #11, on 5/30/13 at 2:21 PM, revealed the resident was in physical therapy, on O2 at two liters and the staff was working with the resident on his/her balance. The staff were checking the oxygen saturation, during exertion. There was no signage to alert staff, residents, or visitors there was oxygen in use on the outside door of the physical therapy room.</p> <p>An observation of Resident #11, on 5/30/13 at 2:30 PM, revealed the resident returned to the room from the therapy room and the O2 concentrator was plugged into the wall outlet, at 2 liters per minute per nasal canula. Another observation on 5/30/13 at 3:39 PM, revealed a</p>	F 323	<p>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>	6/28/2013

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F 323	<p>Continued From page 8</p> <p>visitor with Resident #11, in the room with O2 in use. There was no signage on the doorway to alert staff, residents, or visitors that there was O2 in use in the room.</p> <p>Interviews with Licensed Practical Nurse (LPN) #2 and LPN #3, on 5/31/13 at 3:43 PM, revealed the signage was usually placed on the resident's admission and they would have expected a sign to have been placed on any room that had a resident using O2.</p> <p>An interview with State Registered Nurse Aide (SRNA) #6, on 5/31/13 at 4:00 PM, revealed the "oxygen in use" signage was usually placed by the nurses. She stated there should be a red magnetic sign placed on the doorway of any resident with O2 in use.</p> <p>An interview with the Director of Rehabilitation, on 5/31/13 at 12:40 PM, revealed they have residents come into the physical therapy room, with oxygen being used. She stated they had a sign on the doorway of the previous physical therapy room but stated there had not been one placed outside the current physical therapy room, to notify staff or visitors O2 was in use in the therapy room.</p> <p>An interview with the Administrator, on 5/31/13 at 12:30 PM, revealed the facility has a no smoking policy; however, observations on 05/30/13 at approximately 2:30 PM revealed there were other residents receiving O2, with signage outside the room, stating "no smoking oxygen in use".</p>	F 323		

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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 (200).</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1970, with 35 smoke detectors and 2 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1970 and upgraded in 2012.</p> <p>GENERATOR: Type II generator installed in 2011. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 05-29-13. McCracken Nursing and Rehab Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for One-Hundred Three (103) beds with a census of Seventy-Eight (78) 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

TITLE

(X6) DATE

*Marilyn Hogan*

Administrator

6/21/13

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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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000			
K 056 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for One-Hundred Three (103) beds with a census of Seventy-Eight (78) on the day of the survey. The facility failed to ensure the sprinkler heads were not blocked by light fixtures and ceiling fans in thirteen (13) areas and five (5) areas had proper sprinkler coverage.	K 056	1. Light fixtures will be moved or replaced to prevent blocking of the sprinkler heads located in the bathroom of resident room #314, bathroom of room 309, Therapy area, copy room, personnel office and business office by facility maintenance staff. Ceiling fans will be removed to prevent the blocking of sprinkler heads in the following areas: Therapy office, Human Resources office, Business Office, Nurses station 1, Nurses station 2, nourishment center and the dietary office by facility maintenance staff. Sprinkler heads have been installed by Premier Fire on June 20 <sup>th</sup> , 2013 in the following areas: Closets of rooms #322, 320 and 301, Therapy and Central Bath on hall 2 over toilet area. 2. On 6/19/2013, the Director of Maintenance completed an audit of all sprinkler heads throughout the facility and did not identify any other sprinkler heads that were blocked by light fixtures or ceiling fans or any areas without proper sprinkler coverage. 3. Maintenance staff were re-trained by the NHA on 6/20/13 on the regulations regarding placement of	7/14/13	

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K 056	<p>Continued From page 2</p> <p>The findings include:</p> <p>Observations, on 05/29/13 between 12:10 PM and 4:00 PM with the Maintenance Director, revealed the sprinkler heads located in the bathroom of resident room #314, bathroom of 309, Therapy area, copy room, Personnel office, and the Business office were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads. Further observations revealed ceiling fans were blocking sprinkler heads in the Therapy office, Human Resources office, Business office, Nurses station 1, Nurses station 2, Nourishment Center, and the Dietary office.</p> <p>Interview, on 05/29/13 between 12:10 PM and 4:00 PM with the Maintenance Director, revealed he was unaware that the light fixtures and ceiling fans could block the spray pattern of the sprinkler head.</p> <p>Observation, on 05/29/13 between 12:10 PM and 4:00 PM with the Maintenance Director, revealed the closets of rooms #322, 320, 301, and Therapy did not have proper sprinkler coverage. Further observation revealed the central bath on hall 2 did not have sprinkler protection over the toilet area.</p> <p>Interview, on 05/29/13 between 12:10 PM and 4:00 PM with the Maintenance Director, revealed he was unaware that the areas were not properly sprinkler protected.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with</p>	K 056	<p>sprinkler heads to prevent obstruction and proper coverage of facility.</p> <p>4. Maintenance staff will make monthly rounds to identify any sprinkler heads that would be potential for obstructions for three (3) months. 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 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>	

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K 056	Continued From page 3 the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.  Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)  <table border="0"> <thead> <tr> <th colspan="2">Maximum Allowable Distance</th> </tr> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)</th> <th>of Deflector Obstruction (in.)</th> </tr> </thead> <tbody> <tr><td>Less than 1 ft</td><td>0</td></tr> <tr><td>1 ft to less than 1 ft 6 in.</td><td>2 1/2</td></tr> <tr><td>1 ft 6 in. to less than 2 ft</td><td>3 1/2</td></tr> <tr><td>2 ft to less than 2 ft 6 in.</td><td>5 1/2</td></tr> <tr><td>2 ft 6 in. to less than 3 ft</td><td>7 1/2</td></tr> <tr><td>3 ft to less than 3 ft 6 in.</td><td>9 1/2</td></tr> <tr><td>3 ft 6 in. to less than 4 ft</td><td>12</td></tr> <tr><td>4 ft to less than 4 ft 6 in.</td><td>14</td></tr> <tr><td>4 ft 6 in. to less than 5 ft</td><td>16 1/2</td></tr> <tr><td>5 ft and greater</td><td>18</td></tr> </tbody> </table> For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference:  Reference: S&C 09-04 Adoption of New Fire Safety Requirements for Long Term Care Facilities, Mandatory Sprinkler Installation Requirement <a href="http://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter09-04.pdf">http://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter09-04.pdf</a>	Maximum Allowable Distance		Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)	of Deflector Obstruction (in.)	Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18	K 056		
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K 062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for One-Hundred Three (103) beds with a census of Seventy-Eight (78) on the day of the survey. The facility failed to ensure the interior of the pipe in the sprinkler system was inspected within the past five (5) years.</p> <p>The findings Include:</p> <p>Sprinkler record review, on 05/29/13 at 10:10 AM with the Maintenance Director, revealed the facility failed to provide documentation that the interior of the sprinkler piping had been inspected within the last 5 years.</p> <p>Interview, on 05/29/13 at 10:10 AM with the Maintenance Director, revealed he was unaware the work had not been completed since his sprinkler company had not noted it on any of his quarterly reports.</p> <p>Reference: NFPA 25 (1998 Edition).</p>	K 062	<ol style="list-style-type: none"> <li>1. Premier Fire Protection scheduled to complete the inspection on the interior of the sprinkler piping on 6/24/2013.</li> <li>2. Premier Fire Protection performed a sprinkler inspection on 06/20/13 with no issues found and inspection will be conducted every five (5) years per NFPA standards.</li> <li>3. Maintenance staff were re-educated on June 20, 2013 by the NHA on NFPA regulations for sprinkler inspection.</li> <li>4. Facility maintenance staff will audit pipe inspection through TELs system monthly for three months.. The Director of Maintenance will insure that tests are complete and update records. The NHA will review records to ensure test is complete. The results of these audits 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</li> </ol>	7/14/13

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K 062	Continued From page 5 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.  Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather)  2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4	K 062		

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K 062	Continued From page 6 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter  2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter  2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction Investigation Maintenance 5 years or as needed Chapter 10	K 062		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure manual activation devices, for the kitchen hood system, was readily available in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for One-Hundred Three (103) beds with a census of Seventy-Eight (78) on the day of the survey. The facility failed to ensure the manual pull for the hood suppression was located in the egress path.  The findings include:	K 069	1. The manual activation system for the hood suppression system was relocated on 6/3/13 by Premier Fire to the left of the exit door. 2. Facility audit by maintenance staff completed to assure if any other manual system activation were in not located in path of egress and none were noted. 3. On 6/20/2013, maintenance staff were re-educated by the NHA on the location of manual activation system for hood suppression system location per NFPA guidelines.	7/1/13

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K 069	Continued From page 7 Observation, on 05/29/13 at 11:46 AM with the Maintenance Director, revealed the manual activation device for the hood suppression system was not located in an egress path. The manual activation device was located around the corner from the cooking area in the dishwashing area.  Interview, on 05/29/13 at 11:46 AM with the Maintenance Director, revealed he was not aware of the manual activation device being required in an egress path.  Reference: NFPA 96 (1998 edition) 7-5.1 A readily accessible means for manual activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other. Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link. Exception No. 2: An automatic sprinkler system.  Reference: NFPA 10 (1998 Edition). 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher	K 069	4. The Director of Maintenance will complete facility rounds monthly for three (3) months to ensure the manual activation system for the hood suppression system is located per NFPA guidelines. The results of these audits 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	
K 143	NFPA 101 LIFE SAFETY CODE STANDARD	K 143		

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K 143 SS=E	Continued From page 8  Transferring of oxygen is:  (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;  (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and  (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to assure the room being used to transfer liquid oxygen was rated per NFPA requirements. The deficiency had the potential to affect two (2) of five (5) smoke compartments, twenty-eight (28) residents, staff and visitors. The facility is certified for One-Hundred Three (103) beds with a census of Seventy-Eight (78) on the day of the survey. The facility failed to ensure the oxygen transferring room had a door and frame rated at a 1-hour fire rating and the room was mechanically ventilated to the outside of the facility.	K 143	1. The Oxygen transferring room will be relocated to another area with a door and frame that have a one (1) hour rating and a mechanical vent will be installed to ensure proper ventilation to the outside by Vanguard Construction. 2. A facility tour on June 16, 2013 by Director of Maintenance did not identify any other area that oxygen is transferred and would require one (1) hour fire resistive door and frame or mechanical ventilation. 3. On 6/20/2013, all maintenance staff was provided re-education by the NHA on NFPA regulations regarding liquid oxygen transferring areas requiring a one (1) hour fire resistive door and frame and mechanical ventilation to outside. 4. The Director of Maintenance will make monthly rounds for three (3) months to ensure oxygen is being transferred in a room that has one (1) hour fire restrictive door and frame and proper mechanical ventilation. The results of these audits 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	6/14/13

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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	
(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 143	<p>Continued From page 9</p> <p>The findings include:</p> <p>Observation, on 05/29/13 at 11:46 AM with the Maintenance Director, revealed the room in which oxygen was being transferred did not have proper ventilation. The room was not equipped with a mechanical vent to the outside of the facility. Further observation revealed the oxygen trans-filling room did not have a 1-hour fire rated door or frame installed on the room.</p> <p>Interview, on 05/29/13 at 11:46 AM with the Maintenance Director, revealed he was unaware the door on the oxygen trans-filling rooms must be fire rated and the room must mechanically vent to the outside.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <ul style="list-style-type: none"> <li>a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and</li> <li>b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and</li> <li>c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.</li> </ul> <p>Transferring shall be accomplished utilizing equipment designed to comply with the</p>	K 143	least quarterly	

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

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K 143	Continued From page 10 performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures. The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.	K 143		