

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

PRINTED: 07/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185412	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/06/2011
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NAME OF PROVIDER OR SUPPLIER LOURDES TRANSITIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1530 LONE OAK ROAD PADUCAH, KY 42003
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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
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F 000	<p>INITIAL COMMENTS</p> <p>An annual survey was conducted 07/05/11 through 07/06/10 and a Life Safety Code survey was conducted on 07/06/11. This facility is in substantial compliance with 42 CFR Part 483 Requirements of Long Term Facilities with no significant deficiencies identified.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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: 07/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185412	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/06/2011
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NAME OF PROVIDER OR SUPPLIER LOURDES TRANSITIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1530 LONE OAK ROAD PADUCAH, KY 42003
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K 000	<p>INITIAL COMMENTS</p> <p>K3 Building: 01</p> <p>K6 Plan Approval: 1980</p> <p>K7 Survey under: 2000 existing</p> <p>K8 SNF</p> <p>Type of structure: Eight (8) story Type 1 protected construction. The original five (5) story structure was constructed in 1968. The last three (3) stories were added in 1981. Sprinkler system (wet system) and fire alarm system were updated at the time of the additions. Facility has a type 1 diesel generator with 20,000 gallons of diesel fuel reserve. All vertical openings are protected throughout by 2 hour fire rated construction. The Transitional Care Unit is located on the sixth (6th) floor and consists of two (2) smoke compartments. The facility is licensed for twenty (20) beds and the census was fifteen (15) the day of the survey.</p> <p>A Life Safety Code survey was initiated and concluded on 07/06/11, for compliance with Title 42, Code of Federal Regulations, 483.70 (a), and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p>	K 000		
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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.