



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

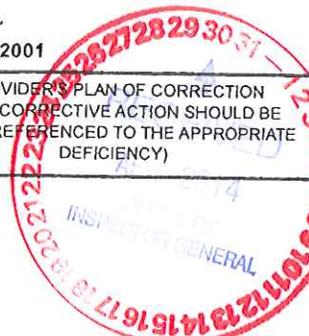
PRINTED: 04/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

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 03/20/2014
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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	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey investigating complaint #KY21422 was conducted 03/18/14 through 03/20/14 to determine the facility's compliance with Federal requirements. Complaint #KY21422 was substantiated with deficiencies cited at a Scope and Severity of a "G".</p> <p>On 02/24/14 at approximately 6:15 AM, Certified Nurse Aide (CNA) #1 was providing perineal care for Resident #1 with him/her facing toward her. As she turned the resident to the other side, the resident slid off the bed into the floor on his/her backside. CNA #1 attempted to guide him/her and brace his/her shoulder against the bed, but was unable to stop the resident's fall. CNA #1 called for assistance from other staff, and stated Resident #1 did not appear to be in any pain. Resident #1 was assessed by Licensed Practical Nurse (LPN) #1 and was assisted back into bed using a lift. About 8:40 AM, Resident #1 was sent to the hospital emergency room, at the Power of Attorney's (POA) request, where x-rays taken were negative for fractures; however, Resident #1 was admitted to the hospital for an irregular heart rate. Later the same day (02/24/14), the facility received a phone call from the hospital's Social Worker stating Resident #1 had sustained a right femur fracture from the fall at the facility.</p>	F 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>	
F 279 SS=G	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable</p>	F 279		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Handwritten Signature]*

*N/A*

*4/30/14*

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 279	<p>Continued From page 1</p> <p>objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to review and revise a plan of care for one (1) of three (3) sampled residents (Resident #1). Resident #1 was assessed as requiring extensive assistance of two (2) or more staff for bed mobility and toileting; however, the Plan of Care revealed the resident was incontinent of bowel and bladder and required one person and extensive assistance with toileting. Additionally, the resident was assessed as having limitation in range of motion (ROM) of the upper and lower extremity on one side and incontinent of urine and bowel.</p> <p>On 02/22/14, Resident #1 sustained a fall from the bed during incontinent care, which resulted in an injury. At approximately 6:15 AM, Certified Nurse Aide (CNA) #1 was providing perineal care for Resident #1, and as she turned the resident, he/she slid off the bed into the floor on his/her backside. About 8:40 AM, Resident #1 was sent</p>	F 279	<ol style="list-style-type: none"> <li>Resident # 1 discharged from facility on 2/22/2014.</li> <li>On 4/23/2014 an audit was conducted by the Director of Nursing/Assistant Director of Nursing, Material Data Set (MDS) Nurses and the Unit Managers on all current residents' care plans to ensure that the care plans reflect all the needs of the residents related to the overall MDS assessment. Any discrepancies were discussed by the Interdisciplinary Team (IDT) and changes were made to the care plans based upon the Interdisciplinary Team's recommendations.</li> <li>The Interdisciplinary Team was reeducated on 4/23/2014 by the Director of Nursing on ensuring upon completion of the most recent Material Data Set (MDS) that the entire MDS is taken into consideration when developing a comprehensive care plan.</li> <li>The Director of Nursing, and or the Assistant Director of Nursing will review five (5) residents' chart weekly times three months to ensure that the residents' Comprehensive Plan of Care is developed, reviewed, and revised utilizing all areas of the MDS assessment. 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</li> </ol>		

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F 279	<p>Continued From page 2</p> <p>to the hospital emergency room, where x-rays revealed he/she had a fractured right femur.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses which included Late Effect Hemiplegia Dominate Side, Sepsis, Diabetes Without Complication Uncontrolled, Joint Contracture-Hand, Intracranial Hemorrhage NOS, Abnormal Posture, Aphasia, Status Amputation Lower Limb NOS, Depressive Disorder NEC, Anxiety State NOS, Non-Alzheimer's Dementia, Renal Failure NOS, Muscle Weakness, and Peripheral Disease. Review of the facility's Minimum Data Set (MDS) assessment, dated 02/20/14, revealed the facility assessed Resident #1's cognition as cognitively intact with a Brief Interview for Mental Status (BIMS) score of fourteen (14), and, as requiring the extensive assistance of two (2) or more staff for bed mobility and toileting. The resident was also assessed as having limitation in range of motion (ROM) of the upper and lower extremity on one side and was incontinent of urine and bowel.</p> <p>Review of the seven (7) day Activities of Daily Living (ADL) Coding Summary, dated 02/14/14 - 02/20/14, revealed under physical functioning and structural problems, Resident #1 required the assistance of two (2) persons with bed mobility eleven (11) times out of twenty (20), with extensive assist. In addition, Resident #1 required the assistance of two (2) persons with toileting twelve (12) of nineteen (19) times, with extensive assist. Review of Resident #1's Fall Risk Assessment, dated 02/20/14, revealed a score of thirteen (13), which indicated the</p>	F 279	<p>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>	4/26/2014
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F 279	<p>Continued From page 3</p> <p>resident was a high risk for falls.</p> <p>Review of the Comprehensive Care Plan for Self Care Deficit, dated 02/18/14, revealed an intervention for the assistance of two (2) staff for toileting and bed mobility. However, review of the Certified Nurse Aide Care Plan (Activities of Daily Living (ADL) Plan of Care) revealed, for toileting and incontinent of bladder, dated 01/28/14 -03/06/14, the level of support needed for toileting and incontinent of bladder was one (1) person, and there was no intervention that addressed how much assistance was needed for bed mobility.</p> <p>Review of the facility's Incident Report, dated 02/22/14 at 6:29 AM, revealed Certified Nurse Aide (CNA) #1 called out for help. Licensed Practical Nurse (LPN) #1 entered Resident #1's room and noted Resident #1 was sitting on the floor on his/her bottom. LPN #1 assessed Resident #1 with no complaints of pain and no signs or symptoms of hitting his/her head. Resident #1 was not able to communicate what had happened. No injuries were noted. Three (3) CNAs assisted Resident #1 back to bed with a mechanical lift.</p> <p>Review of the facility's Investigation revealed, on 02/24/14, it was reported Resident #1 was admitted to the hospital after a fall at the facility. CNA #1 reported, at approximately 6:15 AM, while she was providing perineal-care for Resident #1, the resident slid off the side of the bed. Resident #1 was assessed by the Charge Nurse and no pain was noted. Resident #1 was then sent to the hospital emergency room where x-rays were negative for fractures. Resident #1 was admitted to the hospital for an irregular heart rate and later that day the facility received a</p>	F 279			

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F 279	<p>Continued From page 4</p> <p>phone call from the Social Worker at the hospital stating Resident #1 had sustained a right femur fracture from the fall.</p> <p>Four (4) attempts to reach CNA #1 per phone on 03/19/14 and 03/20/14 were unsuccessful and the CNA no longer worked at facility. However, review of a written statement, dated 02/24/14, provided by CNA #1, revealed she had provided care for Resident #1 on 02/21/14, on the 10:30 PM to 6:30 AM shift. She stated she had made rounds and provided care for Resident #1 throughout the night without any problems. On the final round at approximately 6:15 AM - 6:30 AM, she went in the room to provide care for Resident #1. When she turned Resident #1 toward the window, Resident #1 started to slide off the bed. She attempted to catch Resident #1 but could not stop Resident #1 from continuing to slide off the bed. She braced Resident #1's shoulder to the bed to help ease the resident to the floor. She assisted the resident into a sitting position beside the bed and called for assistance. She stated Resident #1 did not appear to be in any pain. LPN #1 came to the room, assessed Resident #1, then Resident #1 was lifted off the floor with a mechanical lift with the assistance of three (3) CNAs and placed back into bed.</p> <p>Interview with LPN #1, on 03/19/14 at 9:10 AM and 2:48 PM, revealed she was assigned to Resident #1 when he/she fell. She stated she was at the nurse's station when CNA #1 called her to Resident #1's room. She revealed Resident #1 was on the floor behind the bed. She stated CNA #1 did not offer an explanation of how the fall occurred and she assumed CNA #1 found Resident #1 on the floor. LPN #1 stated she asked CNA #1 what happened and CNA #1 did</p>	F 279		
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F 279	<p>Continued From page 5</p> <p>not say anything. The LPN stated CNA #1 then asked for assistance to get Resident #1 up from the floor. She assessed him/her first, asked for assistance from other staff and used the lift to place Resident #1 back in bed. LPN #1 stated there were no obvious injuries. She stated Resident #1 appeared to be irritated by the look on his/her face; however, when the nurse moved his/her right leg, he/she did not seem to be hurt or in any pain. She notified the resident's sister, told her he/she had fallen and did not appear to be injured. The sister stated she would be at the facility later to check on Resident #1. The LPN stated there was no indication the resident needed to be sent out to the hospital. LPN #1 notified the Director of Nursing (DON) about the incident and wrote a statement about what happened. LPN #1 stated she gave report to the oncoming shift just after it happened. She stated she filled out the incident report, but did not recall when she spoke to the DON. LPN #1 stated she thought she told the DON that she did not know how Resident #1 fell out of bed. She stated she was sure Resident #1 was assistance of two because the resident did not help at all.</p> <p>Interview with CNA #2, on 03/19/14 at 10:00 AM, revealed she always requested another staff for assistance when giving Resident #1 a bath, changing him/her, or providing incontinent care. The CNA stated the resident was top heavy and only had one leg.</p> <p>Interview with CNA #4, on 03/19/14 at 10:10 AM, revealed she was trained for two (2) people to bathe Resident #1 because he/she was top heavy. The CNA stated staff would assist him/her to roll and turn on his/her side and always used two (2) staff. She also stated she would use two</p>	F 279		

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F 279	<p>Continued From page 6 (2) staff for perineal-care.</p> <p>Interview with CNA #5, on 03/19/14 at 1:00 PM, revealed she had taken care of Resident #1 only once, but used two (2) assist for perineal care.</p> <p>Interview with LPN #3, on 03/20/14 at 8:25 AM, revealed nurses update care plans if there had been a change or residents had gone to the hospital and come back with something new. She stated she did not recall being there when Resident #1 came back from the hospital, on 02/13/14. She stated she went through the care plan a day or so after he/she came back and had put the date he/she came back on the care plan. She stated she did not change the resident's care plan from one assist to two assist for toileting. She stated she did not recall if it had been changed when she reviewed it.</p> <p>Interview with the Minimum Data Set (MDS) Registered Nurse (RN) #1, on 03/19/14 at 3:20 PM, and on 03/20/14 at 12:30 PM, revealed she assessed residents for functional ability, looked at reports, checked the Accu-Nurse and the seven (7) day ADL tracking. She stated Resident #1 needed quite a bit of assistance. The MDS RN stated they looked at the whole seven (7) days and determined how much assistance was needed. She further stated they do all the Comprehensive Care Plans, and update once a quarter or with any significant change. The nurses update in between these times. She stated the dates on top of the care plans revealed when they were updated. Resident #1's care plan indicated it was updated on 02/18/14. She stated there was no way to know when toileting was changed from one assist to two assist. She stated Resident #1 was assessed as an assist of</p>	F 279		

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F 279	Continued From page 7  two (2) for toileting one or more times and Resident #1's care plan would need to indicate the resident needed two (2) assist. She stated the CNAADL Plan of Care was updated on the Accu-Nurse. The MDS nurse updated it or the nurses on the floor could update it. On all the MDS assessments, the annual and two (2) quarterly, Resident #1 was two assist for toileting. MDS RN #1 stated she did the assessment on 11/20/13 and would have changed Resident #1 to two (2) assist, and she could have updated and changed Resident #1 to two (2) assist for toileting. She stated it only takes one time for two (2) people to move Resident #1 in bed to code him/her assist of two on the MDS.  Interview with MDS RN #2, on 03/19/14 at 3:45 PM, revealed information pulls from Accu-nurse ADLs what CNAs put in the Accu-nurse, look at therapy notes and assess residents. The Quarterly assessment reference date was 02/20/14, and we looked back seven (7) days for ADLs. She stated they do CNA care plans on quarterly updates. Resident #1 was coded a three (3) but that did not always match the care plan, because it only takes one time of two people or more needed to code a three (3). She stated Care Plans were reviewed weekly by the team which consists of the DON, Dietary, Social Services, and Nursing. Further interview revealed they compared the care plans to the Accu-nurse. She stated they were told from the Regional Office to update the CNA Care Plan with our quarterlies, annuals, and change of status during care plan reviews to ensure the CNA Care Plan and the Comprehensive Care Plans matched.  Interview with the DON, on 03/20/14 at 9:10 AM	F 279			

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F 279	Continued From page 8 and 11:00 AM, revealed the facility does not have a care plan policy and does not follow any standard of practice regarding care plans. She stated she does not know who changed Resident #1's care plan. She stated LPN #3 told her she updated the care plan but did not change Resident #1 from one assist to two assist because he/she was only one assist and would not have changed it on the ADL care plan. The DON stated MDS is always going to code the higher level and is not a reflection of the resident's current status. MDS are done quarterly and there was no significant change during the seven (7) day look back. Accu-nurse care plan reflects what the clinical team deems as the most appropriate care. We have consistent CNAs that work the same wing and if there is a CNA that prefers two assist when turning or doing ADL care with the residents, then he or she would use two people. This does not mean the resident requires two people, the CNA may feel more comfortable with using two people. She stated she would not expect, if a nurse or MDS changed the care plan, to update the CNA ADL care plan unless the clinical team discusses it and it was deemed necessary.  Interview with the Administrator, on 03/20/14 at 11:05 AM, revealed Resident #1's ADL care plan is assist of one for dressing and hygiene. Resident #1 uses briefs and his/her bladder/bowel is one person support and would be one person to clean him/her up. She stated perineal-care would be part of hygiene and she would expect the CNA to follow the ADL care plan. She stated she would expect someone to change the ADL care plan to two assist for toileting if they changed the comprehensive care plan and then stated she was not saying that. She	F 279			

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F 279	Continued From page 9 stated toileting is being assisted to the commode, incontinent care is assist of one on the ADL care plan, and it does not specify on the comprehensive care plan. It is two totally different things. Incontinent care was being performed and she is not knowledgeable of Resident #1 ever being assisted to the commode.	F 279		
F 323 SS=G	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 interview, record review, and review of the facility's Fall Assessment/Intervention Process Policy, it was determined the facility failed to ensure adequate supervision to prevent accidents was provided for one (1) of three (3) sampled residents (Resident #1). Resident #1 sustained a fall from the bed during incontinent care on 02/22/14 which resulted in an injury.  Certified Nurse Aide (CNA) #1 was providing perineal care for Resident #1, on 02/24/14, at 6:15 AM, with him/her facing toward her. As she turned the resident to the other side, the resident slid off the bed into the floor on his/her backside. About 8:40 AM, Resident #1 was sent to the hospital emergency room, at the Power of Attorney's (POA) request, where x-rays taken	F 323		

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F 323	Continued From page 10 which revealed the resident had a right femur fracture.  The findings include:  Review of the facility's "Fall Assessment/Intervention Process", last revised 09/13, revealed all residents on admission, re-admission, and at least quarterly would be assessed for fall risk and appropriate interventions initiated immediately to reduce the risk of injuries with falls. The facility must ensure each resident receives adequate supervision and assistance devices to prevent accidents. The clinical Quality Assurance (QA) team along with the Interdisciplinary Team (IDT) may form a sub-committee to review and implement additional interventions for target residents who are high risk for falls. The fall risk assessment is also to be completed quarterly and annually by the Minimum Data Set (MDS) Manager or designee to compliment the MDS schedule and allow for resident review whether a fall has occurred or not. The Accu-Nurse-Care Plans are updated frequently for point of care needs of the resident to ensure safety and accurate care was being delivered.  Record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses which included Late Effect Hemiplegia Dominate Side, Sepsis, Diabetes Without Complication Uncontrolled, Joint Contracture-Hand, Intracranial Hemorrhage NOS, Abnormal Posture, Aphasia, Status Amputation Lower Limb NOS, Depressive Disorder NEC, Anxiety State NOS, Non-Alzheimer's Dementia, Renal Failure NOS, Muscle Weakness, and Peripheral Disease. Review of the facility's MDS assessment, dated	F 323	<ol style="list-style-type: none"> <li>Resident #1 discharged from facility on 2/22/2014.</li> <li>On 4/23/2014 an audit was conducted by the Director of Nursing/Assistant Director of Nursing and the Unit Managers on all current residents to identify all residents at risk for accidents related to falls. All fall risk assessments as well as assistive devices were reviewed and updated and interventions were implemented, including adequate supervision, consistent with a resident's needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident. Any issues were corrected immediately by the Director of Nursing/Assistant Director of Nursing/and or the Unit Managers. The Administrator and Maintenance Director conducted an environmental round on 4/23/2014 to ensure that the residents' environment was free from hazards and individual resident risk of accidents. Any area identified as a potential risk for accident was immediately corrected by maintenance staff.</li> <li>All nursing staff will be reeducated by the Director of Nursing/Assistant Director of Nursing by 4/25/2014 on ensuring that all residents receive adequate supervision, assistive devices and a environment free from accident hazard based upon the Certified Nursing Assistant Care Plans and Comprehensive Care Plans.</li> <li>The Administrator and Maintenance Director will conduct an environmental round weekly times three (3) months to ensure that the resident's environment remains free</li> </ol>	04/26/14 per DON same as state tag Dh

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F 323	<p>Continued From page 11</p> <p>02/20/14, revealed the facility assessed Resident #1's cognition as intact with a Brief Interview for Mental Status (BIMS) score of fourteen (14) and requiring extensive assistance of two (2) or more staff for bed mobility and toileting. The resident was also assessed as having limitation in range of motion (ROM) of the upper and lower extremity on one side and was incontinent of urine and bowel.</p> <p>Review of the seven (7) day Activities of Daily Living (ADL) Coding Summary, dated 02/14/14 - 02/20/14, revealed under physical functioning and structural problems, Resident #1 required the extensive assistance of two (2) persons. In addition, Resident #1 required the extensive assistance of two (2) persons with toileting. Review of Resident #1's Fall Risk Assessment, dated 02/20/14, revealed a score of thirteen (13), which indicated Resident #1 was a high risk for falls.</p> <p>Review of the Comprehensive Care Plan for Self Care Deficit, dated 02/18/14, revealed an intervention for the assistance of two (2) staff for toileting and bed mobility; however, review of the Certified Nurse Aide (CNA) Care Plan (ADL Plan of Care) revealed for toileting and incontinent of bladder, dated 01/28/14 - 03/06/14, the level of support needed for toileting and incontinent of bladder was one person. There was no intervention that addressed how much assistance was needed for bed mobility.</p> <p>Review of the facility's Incident Report, dated 02/22/14 at 6:29 AM, revealed CNA #1 called out for help. Licensed Practical Nurse (LPN) #1 entered Resident #1's room and noted Resident #1 was sitting on the floor on his/her bottom. LPN</p>	F 323	<p>from hazards. The Director of Nursing/Assistant Director of Nursing will observe five (5) residents weekly to ensure that the residents are receiving adequate supervision and appropriate assistive devices are being used according to the plan of care. 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.</p>	

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F 323	Continued From page 12 #1 assessed Resident #1 with no complaints of pain and no signs or symptoms of hitting his/her head, no injuries were noted. Resident #1 was assisted back to bed by three (3) CNAs, with a mechanical lift.  Review of the facility's Investigation revealed, on 02/24/14, it was reported Resident #1 was admitted to the hospital after a fall at the facility. CNA #1 reported, at approximately 6:15 AM, that while she was providing perineal-care for Resident #1, the resident slid off the side of the bed. Resident #1 was assessed by the Charge Nurse and no pain was noted. Resident #1 was then sent to the hospital emergency room where it was noted x-rays taken were negative for fractures. Resident #1 was admitted to the hospital for an irregular heart rate and later that day the facility received a phone call from the Social Worker at the hospital stating Resident #1 had sustained a right femur fracture from the fall. Follow up to the investigation revealed CNA #1 was providing perineal-care for Resident #1 between 5:30 AM and 6:00 AM. She stated she had cleaned Resident #1 with him/her facing toward her and as she turned him/her to the other side, he/she slid in the floor on his/her backside. CNA #1 attempted to guide him/her and brace his/her shoulder against the bed as she was unable to stop the fall. CNA #1 called for assistance from other CNAs on the wing and LPN #1 to assess Resident #1. CNA #1 stated Resident #1 did not appear to be in any pain. LPN #1 assessed Resident #1 and then the resident was assisted back into bed using a lift. Resident #1 gave no indication he/she was in pain. LPN #1 stated she was called into the room by CNA #1 and observed Resident #1 sitting in the floor between the bed and window when called into the	F 323			

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F 323	<p>Continued From page 13</p> <p>room. After assessing Resident #1 who did not appear to be in pain, LPN #1 instructed the CNAs to assist Resident #1 to bed with the lift. LPN notified the Power of Attorney (POA). LPN #2 stated she was made aware of the fall during report from LPN #1. About 8:40 AM, the POA came to the facility and requested that Resident #1 be sent out. Resident #1 was sent by ambulance service to the hospital emergency room where it was noted the x-rays taken were negative for fractures. The facility was made aware later that Resident #1 had sustained a femur fracture.</p> <p>Review of the Accu-Nurse CNA documentation revealed no evidence of documentation related to Resident #1's fall.</p> <p>Review of a written statement, dated 02/24/14, provided by CNA #1 revealed she had provided care for Resident #1 on 02/21/14, on the 10:30 PM to 6:30 AM shift. On the final round, at approximately 6:15 AM - 6:30 AM, she went in to provide care for Resident #1, and when she turned Resident #1 toward the window, he/she started to slide off the bed. She attempted to catch Resident #1 but could not stop Resident #1 from continuing to slide off the bed. She assisted Resident #1 into a sitting position beside the bed and called for assistance. She stated Resident #1 did not appear to be in any pain. LPN #1 assessed the resident then Resident #1 was lifted off the floor with a mechanical lift with the assist of three (3) CNAs and placed back into bed.</p> <p>Interview with CNA #2, on 03/19/14 at 10:00 AM, revealed she always requested another staff for assistance when giving Resident #1 a bath, changing him/her, and providing incontinent care.</p>	F 323			

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F 323	<p>Continued From page 14</p> <p>The CNA stated the resident was top heavy and only had one leg.</p> <p>Interview with CNA #4, on 03/19/14 at 10:10 AM, revealed she was trained for two people to bathe Resident #1 because he/she was top heavy. The CNA stated staff would assist him/her to roll and turn on his/her sides. She stated she would use two (2) staff for perineal-care. The CNA stated she came in on the morning of the fall and received report from CNA #1 who stated Resident #1 had fallen out of bed but she was not told how it happened. CNA #4 stated Resident #1 had a knot on his/her head and an abrasion on his/her right leg. She revealed Resident #1 complained of pain in his/her back when she laid him/her back in the bed. CNA #4 stated she was feeding Resident #1 when his/her sister came in and told LPN #2 she wanted him/her sent out to be on the safe side.</p> <p>Interview with LPN #1, on 03/19/14 at 9:10 AM and 2:48 PM, revealed she was assigned to Resident #1 when he/she fell. She stated she was at the nurse's station when CNA #1 called her to Resident #1's room. She revealed Resident #1 was on the floor behind the bed. She stated CNA #1 did not offer her an explanation of how the fall occurred and she assumed CNA #1 had found Resident #1 on the floor. The LPN revealed CNA #1 asked for assistance to get Resident #1 up from the floor. LPN #1 assessed him/her first, asked for assistance from other staff and used the lift to place Resident #1 back in bed. LPN #1 stated there were no injuries that she could tell. She stated Resident #1 had an irritated look on his/her face but did not act like he/she was hurt or in any pain. She stated she moved his/her right leg and</p>	F 323			

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F 323	<p>Continued From page 15</p> <p>the resident did not appear to be in pain. She notified his/her sister, told her the resident had fallen and there appeared to be no injuries. The Sister stated she would be in later to check on Resident #1. The LPN revealed there was no indication the resident needed to be sent out. She stated she spoke with the Director of Nursing (DON) about the incident and she wrote a statement about what had happened. LPN #1 stated she gave report to LPN #2 when she came in just after it happened. She stated she filled out the incident report and she did not recall when she spoke to the DON. LPN #1 stated she told the DON she did not know how Resident #1 fell out of bed. LPN #1 stated she was pretty sure Resident #1 was two (2) assist because the resident did not help at all.</p> <p>Interview with LPN #2, on 03/19/14 at 10:20 AM, revealed she received report from LPN #1 who told her Resident #1 had fallen while reaching for drinks on the floor, but found out later he/she fell during care. She stated Resident #1's sister came in and asked if Resident #1 could be sent out to have x-rays. She stated Resident #1's sister called her back and said the hospital was keeping Resident #1 to watch him/her and that he/she had no fractures. LPN #2 stated she later found out he/she had a fracture. She stated two (2) people should provide care for Resident #1 and she believed he/she was care planned for two (2) persons to care for him/her. She stated Resident #1 could be rolled over, but two people did his/her care sometimes.</p> <p>Review of the Emergency Room x-rays of the right tibia and fibula, Computer Tomography (CT) Scan of the cervical spine, CT Scan of the head, and CT Scan of the lower lumbar spine, dated</p>	F 323			

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F 323	Continued From page 16 02/22/14, revealed no fractures and no acute abnormality. However, review of Resident #1's CT of the abdomen and pelvis, dated 02/23/14 at 7:00 PM, revealed "Impression: there is a new fracture involving the proximal right femur. There is a subcapital right femoral neck fracture which is comminuted. There is also a intertrochanteric comminuted fracture. Overall, there is no significant displacement".  Review of the Orthopedic Physician Consultation Report, dated 02/22/14, revealed Resident #1 had a stroke in the past that left him/her paretic on the right upper and lower extremities. Resident #1 does not ambulate and is unable to transfer. He stated he was consulted regarding management of the right hip fracture. Extremities: right lower extremity exam, Resident #1's hip lies in a position of external rotation and in a frogleg position. Resident has pain with attempt of movement of right lower extremity. Diagnostic data: CT scan as well as x-rays show a severely comminuted intertrochanteric hip fracture which extends into the femoral neck region. CT scan verify's the displacement and comminution which is present. Plan: Discussion with the sister regarding treatment and recommendations. Told her given Resident #1's current functional status that a non-operative course would be in Resident #1's best interest. Believe Resident #1 to be a severe risk for postoperative complications if surgery performed.  Interview with the DON, on 03/19/14 at 11:00 AM and 5:00 PM, revealed she had received a call from the Unit Manager on 02/22/14 (who was on call) stating they were sending Resident #1 to the hospital. She stated she asked her why and was told Resident #1 had a fall and his/her sister	F 323			

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F 323	<p>Continued From page 17</p> <p>insisted he/she be sent out for x-rays. She stated the Unit Manager told her Resident #1 fell out of the bed and that she had heard a couple different things. Resident #1 slid out of bed while trying to reach for drinks, and the CNA was giving care and he/she slid off the bed. The DON stated during her investigation she was told both things and that she spoke with the sister who said when she was called, she was told he/she was reaching for something and slid off the bed. The DON stated when she spoke to CNA #1, she told her she was giving perineal-care and Resident #1 slid off the side of the bed and the CNA tried to break his/her fall. CNA #1 told her she turned Resident #1 toward her and he/she started to slide and she tried to break his/her fall. The DON stated Resident #1 was one assist for changes and incontinent care.</p> <p>Interview with the MDS Registered Nurse (RN) #1, on 03/19/14 at 3:20 PM, and on 03/20/14 at 12:30 PM, revealed she assessed residents for functional ability, looked at reports, checked the Accu-nurse, the seven (7) day ADL tracking and assessed the residents. She stated Resident #1 needed quite a bit of assistance. The MDS RN stated they looked at the whole seven (7) days and determined how much assistance was needed. She stated the MDS Nurses completed all the comprehensive care plans, and update them once a quarter or with any significant change. The staff update them between their update.</p> <p>RN #1 further stated Resident #1's care plan indicated it was updated 02/18/14. She stated there was no way to know when toileting was changed from one assist to two (2) assist. She stated Resident #1 was assessed as a assist of</p>	F 323			

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F 323	<p>Continued From page 18</p> <p>two (2) for toileting one or more times and Resident #1's care plan would need to indicate the resident needed two assist. She stated the CNA ADL plan of care was updated on Accu-nurse. She stated the MDS nurses updated it or the nurses on the floor could update it. On all the MDS assessments, the annual and two (2) quarterly, Resident #1 was a two person assist for toileting. MDS RN #1 stated she did the assessment on 11/20/13 and maybe she changed Resident #1 to two person assist. She stated they looked at the MDS as a starting point, the Care Assessment Areas (CAAs), interview staff on what care they were providing and how much the resident could do for themselves. She stated they coded Resident #1 two assist because that's what the ADLs reflected. She stated they do observe care being done; however, she had not observed Resident #1's incontinent care/perineal-care.</p> <p>Interview with MDS RN #2, on 03/19/14 at 3:45 PM, revealed information comes from the Accu-nurse ADLs, what CNAs put in, therapy notes and resident assessments. She stated they do CNA care plans on quarterly updates. Resident #1 was coded a three (3) but that did not always match the care plan. She stated Care Plans were reviewed weekly by the team which consists of the DON, Dietary, Social Services, and Nursing. She stated they compare the care plans to the Accu-nurse. She further stated they were told by the Regional Office to update the CNA Care Plans with our quarterlies, annuals and change of status during care plan reviews to ensure that the CNA care plan and the care plan matched.</p> <p>Interview with LPN #3, on 03/20/14 at 8:25 AM,</p>	F 323			

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F 323	<p>Continued From page 19</p> <p>revealed nurses updated the care plan if there has been a change or residents were readmitted with something new. She stated she went through the care plan a day or so after he/she came back and had put the date he/she came back on the care plan. She stated she did not change the resident from one assist to two assist for toileting. She stated she does not recall if it had been changed when she reviewed it.</p> <p>Interview with Resident #1's sister, on 03/20/14 at 8:55 AM, revealed there was normally two people caring for Resident #1. She stated the resident was sent to the hospital and that's when they found out he/she had the fracture. She stated they could not do surgery on his/her right leg because of his/her heart.</p> <p>Interview with the DON, on 03/20/14 9:10 AM and 11:00 AM, revealed the facility did not have a care plan policy and did not follow any standard of practice regarding care plans. She stated she did not know who changed Resident #1's care plan. She stated LPN #3 told her she updated the care plan but did not change Resident #1 from one assist to two assist because he/she was only a one person assist and would not have changed it on the ADL care plan. The DON stated MDS was always going to code the higher level and that was not a reflection of the resident's current status. She stated the Accu-nurse care plan reflected what the clinical team deemed as the most appropriate care. She stated she would not expect if a nurse or MDS changed the care plan to update the CNA ADL care plan unless the clinical team discussed it and they deemed it necessary.</p> <p>Interview with the Administrator, on 03/20/14 at</p>	F 323		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 03/20/2014
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	
F 323	Continued From page 20 11:05 AM, revealed Resident #1 stayed in the bed most of the time. She stated if you ever use two people in the assessment period or anytime, you want to count the highest number. Sometimes a person may only need one person and sometimes they may need two.	F 323			