

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



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 11/16/2011
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NAME OF PROVIDER OR SUPPLIER WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 KENTUCKY AVENUE 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	INITIAL COMMENTS An annual recerification survey was conducted on 11/15/11 through 11/16/11, and a Life Safety Code survey was conducted on 11/15/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of an "F."	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility's policy/procedure and interview, it was determined the facility failed to promote care in a way which maintained or enhanced a resident's dignity and respect, related to the failure to close the window blinds or the privacy curtain, during a skin assessment for one resident (#3), in a selected sample of eight (8). Findings include: A review of the facility's pollycy/procedure "Resident Dignity" (Revised May 13, 2010), revealed "The Transitional Unit will promote care for the residents in a manner and in a environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality, and enhance residents	F 241	11/15/2011 The Director of TCU took corrective action by apologizing to resident #3 on 11/15/11. The director took further corrective actions by reinforcing with the pool nurse the need to provide dignity and respect of the patient by pulling the curtain and drapes. The staff of transitional care unit will promote care for the residents in a manner that maintains or enhances each resident's dignity and respect in full recognition f his or her individuality , including the practice of curtains and blinds - being closed when patient care or procedures are performed. All TCU residents have the potential for dignity and respect of individuality to be affected, when curtains and blinds are not closed. POC to support regulation F241 Dignity and Respect of Individuality: Measures in place to ensure deficient practice does not recur include: <ul style="list-style-type: none"> TCU unit meetings were conducted by the TCU director on November 28, 29, and 30th 2011 reviewing regulation F 241 and survey findings. The staff was informed that all staff, including pool, would be subject to a random audit. An audit tool will be used to monitor privacy during patient care and procedures. 	12/30/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Polly Bechtold RN/MSN/MHA* TITLE: *VP of Nursing /TCU administrator* (X6) DATE: *12-30-11*

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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NAME OF PROVIDER OR SUPPLIER WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 KENTUCKY AVENUE PADUCAH, KY 42003		
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F 241	<p>Continued From page 1 self-esteem and self-worth."</p> <p>A record review revealed Resident #3 was admitted to the facility on 11/07/11 with diagnoses to include Left Total Knee Replacement, Sickle Cell with Chronic Anemia and Hypertension.</p> <p>A review of a Minimum Data Set (MDS), dated 11/07/11 (5 day assessment), revealed Resident #3 was coded to have a "13" summary score on the Brief interview for Mental Status (BIMS) cognitive assessment, which meant the resident was interviewable. Further review of an Occupational Therapy note, dated 11/08/11, revealed Resident #3 was alert and oriented times four.</p> <p>An observation during a skin assessment for Resident #3, on 11/15/11 at 2:40 PM, revealed Registered Nurse (RN) #3 did not close the three large window blinds or pull the privacy curtain around Resident #3 during the skin assessment.</p> <p>An interview with RN #3, on 11/15/11 at 2:55 PM revealed she should have pulled the privacy curtain and closed the blinds and provided privacy for Resident #3; however, there was no further explanation as to why privacy was not provided.</p> <p>An interview with Resident #3, on 11/15/11 at 2:58 PM revealed, "it could be a problem staff not closing the blinds, I guess people could see in the windows, but I would not want them to see me."</p> <p>An interview with the Director of Nursing (DON), on 11/15/11 at 2:56 PM, revealed the staff should close the blinds and pull the curtains to provide</p>	F 241	<ul style="list-style-type: none"> 12/8/2011 Policy # R5.7-TCU "Resident Dignity" was reviewed and revised. "Provide privacy to resident's during personal care by closing doors, pulling curtains and closing blinds." was added to the procedure section. A staff communication note book will contain policy #R5.7-TCU, regulation, audit tool and staff signature roster. Staff will be required to sign the roster by 12/23/11 indicating they have read and understand. 12/7/2011 The charge nurse will instruct pool staff working the unit, to read and sign the roster verifying understanding. <p>Monitoring plans to ensure performance solutions are sustained include:</p> <ul style="list-style-type: none"> A privacy/dignity audit tool was developed 12/2/2011 to monitor dignity and respect of individuality during patient care and or procedures. Beginning 12/12/2011 designated charge nurses and the TCU director will perform random audits on licensed and unlicensed staff during patient care or procedures. A minimum of three audits per week for four weeks will be performed followed by two audits monthly. Monitor frequency will be adjusted according to findings. Findings will be reviewed and discussed in the quarterly quality assurance meetings and during monthly unit meetings. 		

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JAN 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185418	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED 11/16/2011
NAME OF PROVIDER OR SUPPLIER WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 KENTUCKY AVENUE PADUCAH, KY 42003	
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F 241	Continued From page 2 privacy for each resident.	F 241		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility's policy/procedure and interview, it was determined the facility failed to ensure it was free of medication error rates of five percent or greater. An observation of the medication pass, on 11/15/11 and on 11/16/11, revealed thirty three medication opportunities with two errors, resulting in a medication error rate of six percent (6%). Findings include: A review of the facility's policy/procedure "Orders and Prescriptions," dated March 2002 and revised July 2011, revealed "The required elements of a complete medication order, including over the counter medications, legend, medication related devices and herbals are: Drug name and strength (trade or generic are both acceptable), route of administration, frequency of administration, PRN (or as needed medications) must have indications for use." In addition, "Orders for tapering of medications without reduction dose and frequency limits is not acceptable. The nurse will contact the prescriber to obtain dose and frequency reduction limits." A record review revealed Resident #4 was	F 332	On 11/15/11 Resident #4 received less than ordered dose of Oxycodone/Acetaminophen per resident request. Nurse failed to pause and verify change with physician. Upon recognition of error the nurse took corrective actions by calling the physician to reconcile the order and received new order for change in dose. On 11/16/11 Resident #4 did not receive Mucinex as ordered. The medication administration record (MAR) did not contain the order. During the 24 hour chart check performed by a licensed nurse, the error was not detected. Corrective action was taken with pharmacy completing a medication event report to initiate an investigation. The medication was then administered upon reconciliation. All residents receiving medications are at risk of a medication error. POC to support regulation F332 free of Medication Error, Rates of 5% or more. Measures in place to ensure deficient practice does not recur include: TCU unit meetings were conducted by the TCU director on November 28, 29, and 30 th 2011 reviewing Federal regulation F 332. o The staff was informed that deviating from the ordered dose was not permissible without a physician order. If a change is needed the physician must be called. o The staff was informed of the purpose and process of the 24 hour chart check; to ensure accuracy of patient care orders and to provide direction to nurses performing the daily review of orders.	24 12/23/2011 PB Polly Cash

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F 332	<p>Continued From page 3</p> <p>admitted to the facility on 11/14/11 with diagnoses to include Hypoglycemia, Encephalopathy and Possible Pneumonia.</p> <p>A review of the physician's order, dated 11/08/11, revealed Oxycodone/Acetaminophen 10/325 milligrams (mg), one tablet to be administered by mouth (po) four times a day, as needed (prn) for pain. In addition, Mucinex 600 mg po was to be administered twice a day.</p> <p>An observation of a medication pass, on 11/15/11 at 4:25 PM, revealed Registered Nurse (RN) #1 administered Oxycodone/Acetaminophen one-half tablet. The medication was broken in half due to the the resident stating that a whole tablot made him/her drowsy.</p> <p>An interview with RN #1, on 11/15/11 at 4:35 PM, revealed the protocol utilized by the nurses on the floor was "we can always give less if a resident requests it, we just cannot give more."</p> <p>An interview with the Director of Nursing (DON), on 11/15/11 at 7:45 AM, revealed she was unaware of this protocol and stated the physician's order should have been clarified.</p> <p>An observation of a medication pass, on 11/16/11 at 8:45 AM, revealed RN #2 did not administer Mucinex as ordered. The physclan's order revealed it was to be administered twice a day.</p> <p>An interview with RN #2, on 11/16/11 at 9:40 AM, revealed the physician's order for Mucinex 600 mg tablet was not captured on the pharmacy print out of the Medication Administration Record (MAR), and the licensed nurse who completed</p>	F 332	<ul style="list-style-type: none"> o Policy #M5.3-TCU Medication Error was reviewed by a pharmacist and the TUC Director on 12/5/2011. No revisions were made. o 12/7/2011 a staff communication note book was developed and will contain the regulation F 332 and policy M 5.3-TCU, a copy of audit tool and a self study. Each licensed nurse will be mandated to sign roster indicating they have read and understand. Due date 12/23/2011. o Starting 12/7/2011 charge nurses on both shifts will have licensed pool nurses read the information in the note book and sign for reading and understanding. <p>Monitoring plans to ensure performance solutions are sustained include:</p> <ul style="list-style-type: none"> o 12/2/2011 a medication administration audit tool was developed based on regulation F332. o To ensure compliance of Policy #M5.3-TCU Medication Error, the pharmacist will observe medication passes biannually; one week in April and one week in October concentrating on medication pass times, medication rates, and proper technique of administration. o All licensed staff working on the transitional care unit will randomly be audited on a medication pass. Designated charge nurse and the director will perform the audits. A minimum of three audits per week for four weeks will be performed with medication error rate figured; followed by one audit weekly unless rate is >5%. 	

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F 332	Continued From page 4 the 24 hour physician's order checks did not pick up on this. An interview with the DON, on 11/16/11 at 3:38 PM, revealed the medication was omitted on the MAR as well as the 24 hour check, and this should not have occurred.	F 332	If the rate is 5% or greater then two audits per week will be performed. The audits will begin the week of December 12, 2011. Results of the audits will be reviewed concurrently and discussed at the quarterly quality assurance meetings. Issues or patterns will be discussed during unit meetings.		
F 371 SS=E	483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's policy/procedure and interview, it was determined the facility failed to ensure food was prepared, distributed and served under sanitary conditions. Observations of the refrigerators and freezers, on 11/15/11 and 11/16/11, revealed four (4) of the eleven (11) units failed to have a thermometer inside of them. In addition, an accumulation of ice was noted on the threshold and air curtains at the entrance to Freezer #12 and #13. Findings include: A review of the facility's policy/procedure utilized for obtaining refrigerator and fraezer	F 371	11/152011 and 11/16/ 2011 survey observation revealed violation of regulation F371 Food procure/Store/ Prepare/serve-Sanitary. All residents may be impacted by dietary services. POC to support regulation F 371. Measures in place to ensure deficient practice does recur include: o 11/16/2011 thermometers were purchased and place in the Freezer #12 and #13 and pass through refrigerators #5 and #6 to correct deficient practice. o Education provided 11/16/2011 to Food and Nutrition Service (FNS) supervisors on regulation F371 and findings of the survey. Education included the need for temperature and ice build checks. Supervisors informed internal and external thermometer checks on all FNS refrigerators and freezers need to occur twice daily and reconciled. Accumulation of ice build up on the threshold and curtain should be checked daily and reconciled.	12/12/2011	

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F 371	<p>Continued From page 5</p> <p>temperatures, dated October 2008, revealed the facility "recommended" the temperatures were to be checked two times a day, monitoring both the outside and inside thermometers, to ensure accurate functioning of the cooler, thermometers and the temperature gauges.</p> <p>An observation of the cold storage units, on 11/15/11 at 9:15 AM and 9:40 AM, revealed Freezer #12 and #13, and the Pass Through Refrigerators, #5 and #6, were not equipped with thermometers inside of them.</p> <p>An interview with the Dietary Food Supervisor, on 11/15/11 at 9:20 AM, revealed monthly temperature logs were to be completed by the shift Supervisors on both morning and afternoon shifts. However, the inside temperatures were not obtained for approximately four months, according to a review of the logs. The Dietary Food Supervisor was unaware the temperatures were not obtained and there were no extra thermometers, in house.</p> <p>An interview with the Dietary Supervisor, on 11/16/11 at 7:30 AM, revealed she obtained inside and outside temperatures for seven (7) of the eleven (11) refrigerators and freezers; however, there were no extra thermometers available and she could not recall if she had made anyone aware of this.</p> <p>An observation of Freezer #12 and #13, on 11/15/11 at 9:05 AM and 11:15 AM, and on 11/16/11 at 8:00 AM, revealed a slick, icy coating on the threshold and doorway entrances and a coating of ice on the lower half of the heavy plastic, air curtain strips that cover doorways.</p>	F 371	<ul style="list-style-type: none"> o FNS staff in-services conducted on 12/7/2011 educating staff on regulation F 371 regarding monitoring internal and external temperatures and ice build up. Staff informed internal and external temperature should be monitored, recorded and reconciled twice daily. Staff informed accumulation of ice build up on the threshold and curtain should be monitored, recorded and reconciled daily. Education included reporting any missing or broken thermometers immediately. o Temperature recording logs will be reviewed by the FNS manager or his designee for accuracy and compliance and shared at daily supervisor meeting. o 11/16/2011 thermometers added to inventory par level to ensure immediate availability. <p>Monitoring plans to ensure performance solutions are sustained include:</p> <ul style="list-style-type: none"> o The storeroom clerk and/or supervisor will monitor, record and reconcile ice build up on the threshold and curtain daily. Immediate action will be taken to maintain a safe working environment. The task will be added to the storeroom clerk cleaning checklist. Current log modified 12/7/2011 to track daily compliance and actions taken to reconcile ice build up. 	

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F 371	Continued From page 6 An interview with the Dietary Food Supervisor, on 11/16/11 at 8:15 AM, revealed he was in the process of having the situation remedied, and did not have a solution at this time.	F 371	<ul style="list-style-type: none"> o Audit tool developed 11/30/2011 for temperature and ice build up monitoring. Audit will occur daily week one and two, starting 12/7/2011 then biweekly week three and four. Audit will then be performed weekly unless issue identified. Audit will be discussed at quarterly quality meeting. 		

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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: 1972</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Six (6) story, Type I (443) protected</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system</p> <p>GENERATOR: Type I generator, fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 11/15/11. Western Baptist Hospital Transitional Care was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for twenty four (24) beds and the census was twenty four (24) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Polly Bachold RN / MSN / MHA

TITLE
V. P. of Nursing / Administrator

(X5) DATE
12-9-11

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K 000	Continued From page 1	K 000		
K 050 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire drill review it was determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for twenty four (24) beds with a census of twenty four (24) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Drill review, on 11/15/11 at 1:00 PM, with the Safety Director revealed the fire drills were not being conducted at unexpected times under varied conditions. First shift fire drills were routinely being conducted between 5:30 AM to 5:40 AM.</p>	K 050	<p>11/15/2011 Informed the Director and Supervisors of Engineering, Safety, Biomed, Security and Laundry that the Fire Drills on the first shift were not being performed at random times under varied conditions according to NFPA standards. Changes made on conducting drills accordingly.</p> <p>Random drill 4:59pm 11/15/11 Random drill 10:08am 11/18/11</p> <p>POC to support regulation K050: Add random drills to the Preventative Maintenance Program 12/7/2011. Program will print out computer generated random PM's one for each quarter and each shift. Fire drill will be conducted accordingly. Assigned Engineering Staff have been trained and are competent on conducting Fire Drills. 12-7-11 The Hospital Safety Officer and Engineering Supervisor will monitor all drills for compliance with the 2000 edition of NFPA 101 19.7.1.2. Fire drill critique will be signed to verify compliance.</p>	12/7/2011

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - WING A, FLOOR 3 B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2011
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
K 050	Continued From page 2 Interview, on 11/15/11 at 1:00 PM, with the Safety Director revealed he was not aware the fire drills were not being conducted as required. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050		