

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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/15/2013
NAME OF PROVIDER OR SUPPLIER WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 KENTUCKY AVENUE PADUCAH, KY 42003	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS A recertification survey was initiated on 02/13/13 and concluded on 02/15/13 and a Life Safety Code survey conducted on 02/14/13 with the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 332 SS=E	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, interview, record review and review of the facility's policy, it was determined the facility failed to ensure a medication pass error rate of 5% or less. Observation during the medication pass revealed a medication error rate of 7.31%. Two (2) of three (3) nurses were observed with three medication errors in forty-one opportunities. The findings include: Review of the facility's policy regarding Medication Administration Methods, dated 07/2011, revealed staff were check the medication three times: before removing it from the medication storage area; against the MAR or order after removal from storage area; and after opening the package for administration to the patient.	F 332	Residents with potential affect from the deficiency have been identified as those residing in the Transitional Care Unit. On 2/14/13 immediately after Director was notified of the medication error rate, all licensed staff were assembled and instructed on the errors made on resident #2, a, #5. Resident #2: directions were not followed for blood pressure prior to administration with specific hold requirements. Instructed to read and follow pharmacy instructions and/or physician parameter orders. Resident A: Proper technique of eye drop administration was not followed. Eye drops should be placed in mid to lower fornix or as directed by pharmacy recommendations which are based on the manufactures recommendation. Instructed to read and follow pharmacy instructions and/or physician orders. Resident #5: The splitting of the potassium supplement and not giving with 4-8 oz. water and doing all possible to have resident take 4-8 oz. water was not met. Instructed to read and follow pharmacy instructions and/or physician parameter orders. Any change from recommendation	March 29, 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Polly Bechtold R/L/MSN/MHA* TITLE: *VP Nursing TCU Administrator* (X6) DATE: *3/6/13*

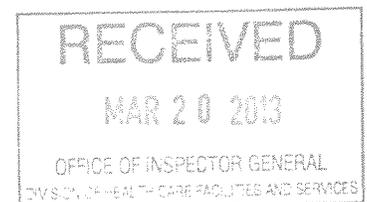
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/15/2013
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			

<p>F 332 Continued From page 1</p> <p>1. Observation, on 02/14/13 at 8:30 AM, revealed RN #1 administered 10 medications to Resident #2. One medication scheduled for Resident #2 was Atenolol 25 mg with specific instructions to hold medication if systolic blood pressure was less than 110. RN #1 administered the medication and did not check the blood pressure before administration.</p> <p>Interview with RN #1, on 02/14/13 at 9:00 AM, revealed she failed to check the resident's blood pressure before administration and should have. She stated she was just trying to do everything right and just forgot.</p> <p>Interview with the Director of Nursing, on 02/15/13 at 9:30 AM, regarding the medication error rate revealed the facility had worked very hard since the last survey to train staff on medication errors. She stated last years error was from an omission and this years errors were not reading the special attention area's.</p> <p>2. Review of the facility's policy regarding Medication Administration Methods, Revised July 2011, revealed the staff was to instill eye drops with the lower lid of the patient drawn down with gentle pressure on the maxillary prominence and the patient looking upward. The policy continued to state to drop the medication in the mid lower fornix, which was the part of the conjunctiva overlying the cornea.</p> <p>Review of the physician's order for Resident A revealed an order for Moxifloxacin Hydrochloride</p>	<p>F 332</p> <p>has to have an order by physician and noted in the care plan. On 2/15/13 there was documentation by the physician to split due to esophagitis from radiation treatment and documented in the care plan. All residents receiving medications are at risk of a medication error. Plan of correction to support regulation F332 free of medication error rates of 5% or greater: include:</p> <p>Transitional Care Unit meetings conducted by the TCU nursing Director on February 25, 26, and 28, 2013 presented in-service on Federal regulation 332; Staff instructions:</p> <ul style="list-style-type: none"> Heart rate and B/P needs to be taken prior to medication administration when specific guidelines are noted in physician order and or pharmacy direction based on manufacturer recommendation. Proper technique of eye drop administration should be followed per order or pharmacy direction based on manufacturer recommendation. Manufacturer recommendations in relation to water 4-8 oz. with specific medications and not crushing/splitting medications. Regulation F332 on medication administration was in-serviced in detail to cover other significant areas to eliminate errors. 3/4/13 a competency was developed by the TCU director covering multiple areas of proper medication administration and the
--	--



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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/15/2013
NAME OF PROVIDER OR SUPPLIER WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 KENTUCKY AVENUE PADUCAH, KY 42003	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5) COMPLETION DATE			

F 332 Continued From page 2
0.5% eye drops to be instilled in both eyes three times a day as needed.

Observation, on 02/14/13 at 8:05 AM, during the medication pass revealed Registered Nurse (RN) #3 instilled eye drops into the eyes of Resident A by pulling up on the upper lid and dropping the medication onto the eye of Resident A.

Interview, on 02/15/13 at 3:00 PM, with RN #3 revealed she was not aware of a policy for the instillation of eye drops. In addition, she revealed she had always instilled eye drops by lifting up the upper lid.

3. Review of the policy Medication Administration Methods, Revised July 2011, revealed medication was to be checked against the Medication Record (MAR) or order prior to administration.

Review of the physician's order for Resident #5 revealed an order for Potassium Chloride 10 meq to be administered twice a day with meals. The order specified to take the medication with a full glass of water, take with food, and swallow whole, do not spill, crush or chew.

Observation, on 02/04/13 at 9:25 AM, during the medication pass revealed RN #3 administered the ordered Potassium Chloride 10 meq pill to Resident #3 after breaking the medication in half.

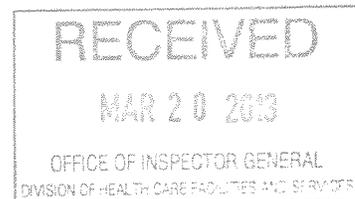
F 332

licensed nurse must be checked off by the charge nurse or director twice a year.

- 3/7/13 a medication administration test was given to each licensed nurse for independent completion by 3/25/13 with 100% passing score required.

Monitoring plans to ensure performance solutions are sustained include:

- 3/4/13 medication administration audit tool developed to include all aspects of Federal regulation F332. Four nurses will be randomly audited monthly during medication pass by charge nurse, director, or pharmacist. Individuals will be stopped by the evaluator during the med pass observation if an error is about to occur and immediate education will be given to the nurse. Any further potential errors identified by the same nurse will result in counseling and an action plan for the individual nurse. At a minimum of monthly the TUC Director will have the nurse evaluated with a med. pass.
- Medication administration in-service will be repeated in six months (August 2013).
- Results of test will be evaluated and areas needing improvement will receive further education and followed closely with medication passes.



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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/15/2013
NAME OF PROVIDER OR SUPPLIER WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 KENTUCKY AVENUE PADUCAH, KY 42003	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 332 Continued From page 3
Interview, on 02/05/13 at 3:00 PM, with RN #3 revealed she broke the medication in half for the ease of the resident to swallow. RN #3 revealed she had not looked at the additions to the the order.

F 332

- The TCU Quality Assurance Committee will address and evaluate medication errors on a quarterly basis. Reporting will be added to the quarterly QA meetings. Next quarterly meeting April 2013.

F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS
SS=D

F 431 Residents with potential affect from the deficiency have been identified as those residing in the Transitional Care Unit. On 2/13/13 immediately after Director was notified of expired IV fluids, Director and licensed staff discarded noted expired IV fluids. Between 2/13-15/13 all IV fluids in the department were checked for expired dates by licensed staff. Nursing staff on TCU were educated during unit meetings on February 25, 26 and 28th to recheck expiration dates prior use. POC to support Federal Regulation 431 Drug Records, Label/Store Drugs & Biologicals include:

March 29, 2013

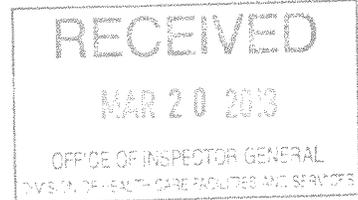
The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can

- Change to Policy R15.1CD to revise and include: IV fluids will be pulled one month prior to expiration date following stock rotation system and date verification.
- Change made to Policy R 21.4CD revised and include: The Central Distribution tech will check dates and rotate stock when placing stock on units. IV fluids will be pulled one month prior to expiration date. Any other product will be pulled by first day of the month it will expire. On the first day of the month the Central

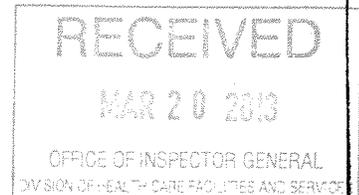


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/15/2013
NAME OF PROVIDER OR SUPPLIER WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 KENTUCKY AVENUE PADUCAH, KY 42003	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 431	<p>Continued From page 4 be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure intravenous fluids ready for use were not expired. Two (2) of four (4) intravenous (IV) fluids of 5% Dextrose 500 milliliter bags were expired in October 2012 and December 2012.</p> <p>The findings include:</p> <p>Review of the facility's policy Rotation of Supplies, revised February 2008, revealed the Central Distribution Technician was to ensure sterile items do not get pushed to the back of the shelf and become outdated. Expiration dates on items should be checked frequently. This applied to everything dispensed in Central Distribution.</p> <p>Observation, on 02/13/13 at 11:25 AM, of the medication room revealed six different boxed areas for the storage of intravenous fluids. One boxed area had 4 bags of intravenous fluids, 5% Dextrose 500 milliliter bags with 2 of the bags expired in October 2012 and December 2012.</p> <p>Interview with the Director of Nursing, on 02/15/13 at 9:30 AM, revealed Central supply was responsible for stocking IV fluids and checking for expiration dates of the supplies they stocked.</p> <p>Interview with the Central Supply Supervisor, on 02/15/13 at 9:50 AM, revealed their department was responsible to stock IV fluids and check for</p>	F 431	<p>Distribution tech will check all stock for upcoming expiration dates.</p> <ul style="list-style-type: none"> Expiration dates will be checked when placing stock on shelves in storeroom, insuring that stock is being rotated properly and new stock is put in appropriate location per rotation policy. All stock on the first day of the month will be checked for expiration dates by Central Distribution tech on scheduled run to departments. Random audits by the supervisor or appointed Central Distribution tech will be performed monthly to ensure compliance. Each month a supply area will be audited for expiration dates to ensure compliance. Any out of date findings will be reported to the TCU Director. CD Director. Staff counseling and education will be performed with corrective action plans if necessary. An in-service will be conducted by the Materials Management Director with all Central Distribution techs to cover new procedures and policy by March 29, 2013. The TCU Quality Assurance Committee will address and evaluate the audit findings with each quarterly meeting. Any recommendations will go to the
-------	--	-------	---



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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/15/2013
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 431 Continued From page 5
expiration dates. He stated they should be checked at least on a daily basis. He stated he did not know what the outcome would be if expired IV fluids were used, but they should not be used if they are expired.

F 431 Central Distribution Director.
Next quarterly meeting April 2013.

F 468 483.70(h)(3) CORRIDORS HAVE FIRMLY SS=E SECURED HANDRAILS

F 468 Residents with potential affect from the deficiency have been identified as those residing in the Transitional Care Unit. No residents in the facility were found to be affected by the identified deficiency. March 29, 2013

The facility must equip corridors with firmly secured handrails on each side.

On 2/15/13 immediately after Director was notified of loose hand rails, the Director of TCU and Engineering met to determine needs to meet standard F468 483.70 Corridors Have Firmly Secured Handrails. Plan of correction for F468 483.70 Corridors Have Firmly Secured Handrails.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview it was determined the facility failed to equip corridors with firmly secured handrails. Five (5) of sixteen (16) handrails in the Transitional Care Unit (TCU) were not firmly affixed to the wall.

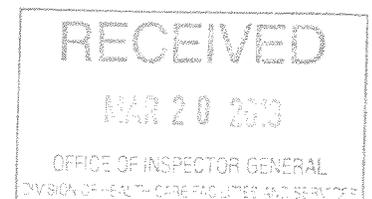
- Engineering tightened and repaired all loose handrails 2/15/13.
- New handrails were ordered on February 17, 2013. Handrails on entire floor to be installed by 3/29/13.
- Handrails will be added to the March 20, 2013 quarterly unit compliance audit and rails will be checked for any repair issues. Thereafter handrails will be included on the quarterly unit compliance audits. TCU compliance member completes this quarterly report and will add any repairs needed to the daily engineering repair sheet for correction. Immediate needs will be called.

The findings include:

The facility did not provided a policy related to the handrails.

Observation, on 02/13/13 at 10:45 AM, during the tour of the facility revealed a loose handrail outside Room 673 on the right facing the door.

Observation, on 02/13/13 at 1:22 PM, revealed loose handrails outside Room 688 on the right, facing the door and outside Room 694 on the left, facing the door. Additional observations revealed a loose handrail outside Room 670 on the right as you face the door and a loose handrail on the right outside the Physical Therapy Department as you face the door.



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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/15/2013
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)

F 468 Continued From page 6
Observation, on 02/05/13 at 8:45 AM, outside the Physical Therapy Department revealed Resident #7 engaged in physical therapy holding on to the handrail.

Interview, on 02/13/13 at 1:32 PM, with the Engineer responsible for the TCU revealed he was responsible to check the handrails, which he did every couple months, but not on a regular basis and that the handrails were not on a preventative maintenance schedule. He revealed if the nursing staff noted a loose handrail, they would put it on a list (of work requests) which he checked every morning. The Engineer continued by noting the importance of having secured handrails was for helping patients not steady on their feet and who needed a hand hold, something to hang on to to stabilize themselves. Related to the observed loose handrails, the Engineer revealed he should have checked the loose rails but he missed them.

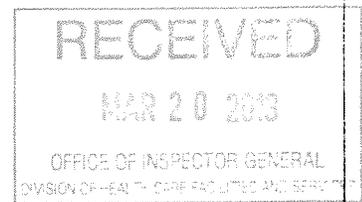
Interview, on 02/15/13 at 7:30 AM, with Certified Nursing Assistant (CNA) #1 revealed the handrails helped to steady the patients when physical therapy or nursing walked them down the hall. She stated the rails needed to be secure so the patients did not fall, for safety reasons. She revealed, if she knew a handrail was loose, she would let the Health Unit Coordinator (HUC) know, and the HUC would notify maintenance.

Interview, on 02/15/13 at 7:35 PM, with the Occupational Therapy (OT) Assistant revealed OT used the handrails for support and stability with the patients. He revealed the handrails need to be secure to prevent falls.

F 468

- The engineering department has instituted a new PM task on a computer generated program to check the handrails on a monthly schedule starting on March 1, 2013 and on the first of every month thereafter. Assigned engineers will perform the checks on their assigned floors.
- The Engineering Department will maintain a log of each PM and record all deficiencies found. This record will be monitored by the EOC Safety Committee during each bimonthly meeting starting May 2013 to ensure compliance.
- The results will be added and reported quarterly to the TCU Quality Assurance Committee for review and Compliance. Next quarterly meeting April 2013.
- Policy E14.1104 ENG will be revised to include preventive maintenance plan of handrails by March 29, 2013.

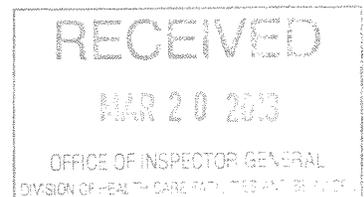
3-28-13
Per Duly Ricketts
by RB 3-25-13



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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/15/2013
NAME OF PROVIDER OR SUPPLIER WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 KENTUCKY AVENUE PADUCAH, KY 42003	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 468	Continued From page 7 Interview, on 02/05/13 at 7:37 PM, with the Physical Therapy (PT) Assistant revealed PT used the handrails for standing exercises. She revealed the handrails offered support and stability and if the handrails were not secured to the wall, the patient could lose their balance and possibly fall. Interview, on 02/15/13 at 10:40 AM, with the Director of Nursing (DON) revealed she knew there was a log at the nursing desk to write maintenance requests in, but she was unaware of the current loose handrails.	F 468	



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

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - FLOOR 6 B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2013
--	--	---	--

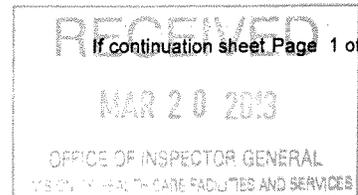
NAME OF PROVIDER OR SUPPLIER WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 KENTUCKY AVENUE PADUCAH, KY 42003
--	--

(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 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01. PLAN APPROVAL: 1972. SURVEY UNDER: 2000 Existing. FACILITY TYPE: SNF/NF. TYPE OF STRUCTURE: Six (6) story, Type 1 (443). SMOKE COMPARTMENTS: Three (3) smoke compartments. FIRE ALARM: Complete fire alarm system installed in 1972 and upgraded in 2011, with 1099 smoke detectors and 78 heat detectors. SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1972 and upgraded in 2010. GENERATOR: Type I generator installed in 1972. Fuel source is Diesel. A standard Life Safety Code survey was conducted on 02/14/13. Western Baptist Transitional Care Unit was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Twenty-Four (24) beds with a census of Fifteen (15) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal	K 000		
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Polly Bechtold RN, MSN, MHA *V. P. of Nursing TCU Administrator* *3/20/13*

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.



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

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - FLOOR 6 B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2013
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 000 Continued From page 1
Regulations, 483.70(a) et seq. (Life Safety from Fire).

K 000

Deficiencies were cited with the highest deficiency identified at "F" level.

K 056 SS=E NFPA 101 LIFE SAFETY CODE STANDARD

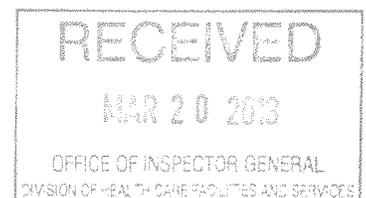
If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, 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

K 056 Residents with potential affect from the deficiency have been identified as those residing in the Transitional Care Unit. No residents in the facility were found to be affected by the identified deficiency. On 2/14/13 immediately after Director notified of standard vs. quick response sprinkler heads in same compartment and gauge on sprinkler risers maintained the Director of TCU and Engineering met to discuss plan of correction for standard K056 HFPA 101 life Safety Code. Plan of correction for standard K056 NFPA 101 Life Safety Code in accordance with NFPA 13 and NFPA 25 include:

March 29,2013

- The standard response sprinkler heads were replace with quick response sprinkler heads in the deficient compartment area located in the two bank elevator area on 2/19/13 by Premier Fire Sprinkler Service.
- The hospital's C-wings with like compartments and Food and Nutrition were surveyed for deficient non-compliant sprinkler heads by a State Certified Inspector and corrected on 2/20/13.

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for Twenty-Four (24) beds with a census of Fifteen (15) on the day of the survey. The facility failed to ensure all sprinkler heads in the same compartment would engage at the same heat level in the two bank elevator lobby.



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

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - FLOOR 6 B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2013
--	--	---	--

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 056 Continued From page 2
The findings include:

Observations, on 02/14/13 at 12:25 PM, with the Safety Officer revealed standard response sprinkler heads and quick response sprinkler heads in the same compartment located in the two bank elevator lobby.

Interview, on 02/14/13 at 12:25 PM, with the Safety Officer revealed he was unaware the sprinklers in the same compartment must match throughout the compartment.

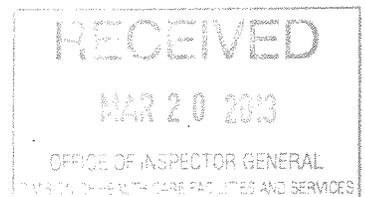
Reference: NFPA 13 (1999 Edition)
7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:

- (1) Wet pipe system
- (2) Light hazard or ordinary hazard occupancy
- (3) 20-ft (6.1-m) maximum ceiling height

The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a

K 056

- A quarterly PM schedule was initiated on March 1, 2013 to survey the entire hospital facility for deficient and non-compliant sprinkler heads and standard response and quick response sprinkler heads in same compartment by a State Certified Sprinkler Inspector.
- The Engineering Department will maintain a log of the PM and record all deficiencies found.
- This record will be reported under Fire Safety and monitored by the EOC Safety Committee during the bimonthly meetings starting May 2013 to ensure compliance. These results will be added and reported to the TCU Quality Assurance Committee for review of compliance. Next quarterly meeting April 2013.



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

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - FLOOR 6 B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2013
--	--	---	--

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 056 Continued From page 3
compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.

K 062 SS=F NFPA 101 LIFE SAFETY CODE STANDARD
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

This STANDARD is not met as evidenced by:
Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for Twenty-Four (24) beds with a census of Fifteen (15) on the day of the survey. The facility failed to ensure the gauges on the sprinkler riser had been replaced or recalibrated within the past five (5) years.

The findings Include:

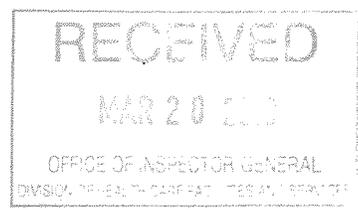
Observation and record review, on 02/14/13 at 12:25 PM, with the Safety Officer revealed the facility failed to provide documentation that the gauges on the sprinkler riser had been calibrated or replaced within the last 5 years.

K 056

K 062 Residents with potential affect from the deficiency have been identified as those residing in the Transitional Care Unit. No residents in the facility were found to be affected by the identified deficiency. On 2/14/13 the facility failed to ensure the gauges on the sprinkler riser had been replaced or recalibrated within the past five years. Plan of correction for standard K062 101 Life Safety Code in accordance with NFPA 13 and NFPA 25 include:

- Premier Fire Sprinkler service scheduled for 3/11/13 to calibrate and or replace gauges on sprinkler system.
- A preventive maintenance schedule has been initiated 3/11/13 and quarterly thereafter to check sprinkler gauges for proper working condition, broken glass and with-in date of calibration on a quarterly basis by a State Certified Sprinkler Inspector.
- The engineering Department will maintain a log of each PM and record all deficiencies found an ensure correction for compliance.

March 29, 2013



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

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - FLOOR 6 B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2013
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)

K 062 Continued From page 4
Interview, on 02/14/13 at 12:25 PM, with the Safety Officer revealed he was not aware the gauges on the sprinkler riser had to be calibrated or replaced once every 5 years.

Reference: NFPA 25 (1998 Edition).
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.

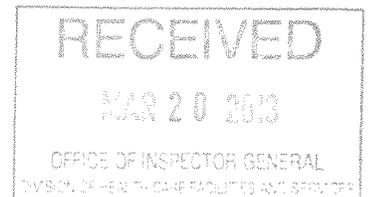
Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance

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

K 062

- This record will be reported under Fire Safety and monitored by the EOC Safety Committee during the bimonthly meetings starting May 2013 to ensure compliance. These results will be added and reported to the TCU Quality Assurance Committee for review of compliance. Next quarterly meeting April 2013.
- Policy M1.1018 ENG will be revised to include preventive maintenance of sprinkler gauge and calibration by March 29, 2103. *3-28-13 Kelly Buchholz*

by PB 3-25-13



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

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - FLOOR 6 B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2013
--	---	--	---

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 062 Continued From page 5
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
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 066
SS=D NFPA 101 LIFE SAFETY CODE STANDARD
Smoking regulations are adopted and include no less than the following provisions:

(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.

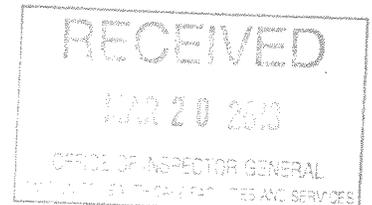
(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.

(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.

K 062

K 066 Residents with potential affect from the deficiency have been identified as those residing in the Transitional Care Unit. No residents in the facility were found to be affected by the identified deficiency.
On 2/14/13 it was found the facility failed to provide approved metal containers with self-closing lid to empty the ash trays into and no fire extinguisher or fire blanket in the smoking areas. Engineering Director reviewed needs to meet standard K066 NFPA 101 Life Safety Coe. Ashtray of non-combustible material and safe design. Plan of correction for standard K066 NFPA 101 Life Safety Code. Ashtray of non-combustible material and safe design and no fire extinguisher in smoking area include:

March 29, 2013



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

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - FLOOR 6 B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2013
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)

K 066 Continued From page 6

K 066

(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4

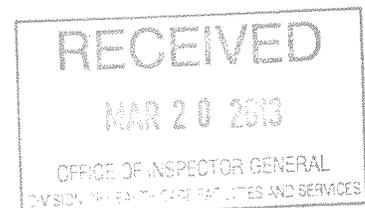
This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays at an entrance, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors who smoke. The facility is certified for Twenty-Four (24) beds with a census of Fifteen (15) on the day of the survey. The facility failed to ensure two (2) smoking areas had a fire extinguisher or a fire blanket available.

The findings include:

Observation, on 02/14/13 at 12:30 PM, with the Safety Officer revealed the two (2) smoking areas did not have an approved metal container with a self-closing lid to empty the ash trays into. Further observation revealed there was no fire extinguisher or a fire blanket in the smoking areas.

Interview, on 02/14/13 at 12:30 PM, with the Safety Officer revealed he was not aware the areas did not have the proper items to be in compliance.

- Metal containers with self-closing cover device have been ordered 3/8/13 and will be installed up their arrival Completion by March 31, 2013.
- Ashtrays of non-combustible material and safe design have been installed on March 14, 2013.
- The deficient containers have been discarded to eliminate the possibility of recurrence. March 14, 2013 by engineering.
- The engineering Department has instituted a new computer generated PM program with task to check the ashtrays on a monthly schedule starting March 1, 2013 and on the first of every month thereafter. Assigned engineers will perform.
- The Engineering Department will maintain a log of each PM and record all deficiencies found and plan of correction for to ensure compliance. This record will be monitored by the EOC Safety Committee during each bimonthly meeting starting in May 2013 to ensure compliance. These results will be added and reported to the quarterly TCU Quality Assurance committee for reviews of compliance. Next quarterly meeting April 2013.



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

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - FLOOR 6 B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2013
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 066 Continued From page 7
Reference: NFPA 101 (2000 edition)
19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions:
(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.
Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.
(2) Smoking by patients classified as not responsible shall be prohibited.
Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision.
(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.
(4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.

K 070 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
Portable space heating devices are prohibited in

K 066

Life Safety Code. no fire extinguisher in smoking area include:

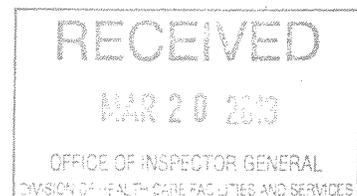
- Fire extinguishers were installed in smoking area on 2/27/13 by the Engineering Department.
- The engineering Department has instituted a new computer generated PM program with task to check the fire extinguishers on a monthly schedule starting March 1, 2013 and on the first of every month thereafter. Assigned engineers will perform.
- The Engineering Department will maintain a log of each PM and record all deficiencies found. This record will be monitored by the EOC Safety Committee during each bimonthly meeting starting in May 2013 to ensure compliance. These results will be added and reported to the quarterly TCU Quality Assurance committee for reviews of compliance. Next meeting quarterly meeting April 2013.
- Policy M1.1018 will be revised to include fire extinguishers in smoking area by March 29, 2013.

*3-28-13 per Holly Bostford
by PB 3-25-13*

K 070

Residents with potential affect from the deficiency have been identified as those residing in the Transitional Care Unit. No residents in the facility were found to be affected by the identified deficiency. On

March 29, 2013



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

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - FLOOR 6 B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2013
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 070 Continued From page 8
all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, ten (10) residents, staff and visitors. The facility is certified for Twenty-Four (24) beds with a census of Fifteen (15) on the day of the survey. The facility failed to ensure (1) space heater was not located in the health care occupied area.

The findings include:

Observation, on 02/14/13 at 12:45 PM, with the Safety Officer revealed a portable space heater located in the east hall shower room.

Interview, on 02/14/13 at 12:45 PM, with the Safety Officer revealed he was not unaware the space heater was being used to heat the shower room.

Reference: NFPA 101 (2000 edition)
19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies.

K 070 2/14/13 the facility was found to have a space heater in violation of K070 NFPA 101 Life Safety Code in accordance to HFPA portable Space Heating Devices. Upon notification to the Director the space heater was removed immediately.

Plan of correction for K070 NFPA 101 Life Safety Code in accordance to HFPA portable Space Heating Devices includes:

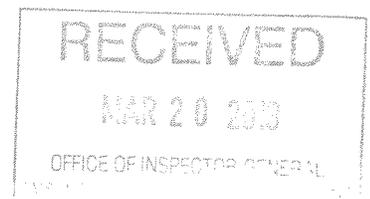
- Heater removed 2/14/13.
- Engineering supervisor conducted in-services to the Engineering staff on heater prohibited use. In-services completed 3/6/13 documented, and kept in Engineering Department.
- Director of TCU provided in-services to TCU staff during unit meeting on February 25, 26 and 28th, 2013. Director stressed there were to be no space heaters used in any patient care areas ever as stated per facility policy house wide.
- The nurse assistance daily assignment sheet will be revised March 26, 2013 to include daily check that there is no space heater in the shower room. Nurse aide education will be completed March 25, 2013 by TCU director with assignment change.
- Any findings will be reported immediately to the charge nurse or director of TCU. The compliance rep. for the unit will monitor with quarterly unit compliance report March 20, 2013 and will report any findings to the director. Unit compliance report including space heater will be quarterly thereafter. The director of TCU will initiate counseling and an action plan with the individual that asked for and or placed a space heater in any patient care area per policy E 17. 5SAF.



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

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

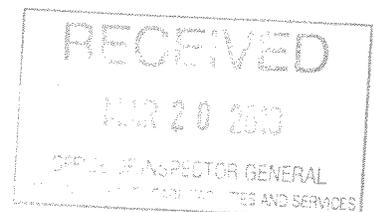
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - FLOOR 6 B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2013
NAME OF PROVIDER OR SUPPLIER WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE		STREET ADDRESS, CITY, 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)
K 070 K 072 SS=F	Continued From page 9 Exception: Portable space-heating devices shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit egress in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for Twenty-Four (24) beds with a census of Fifteen (15) on the day of the survey. The facility failed to ensure medical equipment, scales, and linen carts were properly stored out of the corridor when not in use. The findings include: Observation, on 02/14/13 between 11:30 AM and 1:00 PM, with the Safety Officer revealed medical charting units plugged in to charge in the corridor, two (2) scales, and linen carts stored in the corridor of floor 6.	K 070 K 072	<ul style="list-style-type: none"> The TCU QA Committee will address and evaluate any issue with space heaters in patient care areas in the quarterly meetings. Next quarterly meeting April 2013. <p>Residents with potential affect from the deficiency have been identified as those residing in the Transitional Care Unit. No residents in the facility were found to be affected by the identified deficiency. On 2/14/13 immediately after Director was notified of egress violation, Director and staff assembled to discuss issue and need for identification of storage opportunities. The Director of TCU and the facility Architect met to discuss needs to meet standard K072 101 Life Safety Code. Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. Plan of correction for K072 101 Life Safety Code. Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency includes:</p> <ul style="list-style-type: none"> 2/18/13 all storage and cabinets were cleaned of clutter and evaluated for future storage use. 2/21/13 House Architect rounded for identification of storage opportunity. Areas identified in department to remove items from egresses. <p>Minor renovation needed and will be completed March 22, 2013.</p>
	March 29, 2013	(X5) COMPLETION DATE	



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

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - FLOOR 6 B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2013
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)
K 072	Continued From page 10 Interview, on 02/14/13 between 11:30 AM and 1:00 PM, with the Safety Officer revealed he was aware items could not be stored in the corridor. Interview, on 02/14/13 at 12:40 PM, with a Nurses Aide revealed she routinely stored the medical charting equipment in the corridor and plugged them into the outlets. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	<ul style="list-style-type: none"> Daily monitoring will be performed by the unit assistants and will initial compliance on their daily assignment sheet. The Director and all other staff will visually monitor for items not in use and immediately remove to designated place for storage. The TCU QA committee will address and evaluate any issues regarding egress for compliance. The committee meets quarterly. The next quarterly meeting occurs April 2013.
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for Twenty-Four (24) beds with a census of Fifteen (15) on the day of the survey. The facility failed to ensure two power strips were being used properly. The findings include:	K 147	Residents with potential affect from the deficiency have been identified as those residing in the Transitional Care Unit. No residents in the facility were found to be affected by the identified deficiency. On 2/14/13 immediately after Director was notified of violation failing to ensure power strips were used properly. The Director and staff met to discuss immediate correction to standard K147 NFPA 101 Life Safety Code; Electrical wiring and equipment is in accordance with NFPA 70, Nation Electrical Code 9.1.2. Plan of correction for standard K147 NFPA 101 Life Safety Code; Electrical wiring and equipment is in accordance with NFPA 70, Nation Electrical Code 9.1.2 includes: <ul style="list-style-type: none"> Immediate removal of power strips used on equipment that directly is used on patients.
	March 29, 2013		



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

PRINTED: 02/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - FLOOR 6 B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2013
--	--	---	--

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 147	<p>Continued From page 11</p> <p>Observations, on 02/14/13 at 12:25 PM, with the Safety Officer revealed a CO2 monitor was plugged into a power strip that was plugged into another power strip located in the medicine room.</p> <p>Interview, on 02/14/13 at 12:25 PM, with the Safety Officer revealed he was unaware the power strips were being used in the medicine room.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	<ul style="list-style-type: none"> Monitoring equipment moved to clean utility room with individual plug-ins. Daily monitoring will be monitored by the unit secretary. The daily assignment form was changed March 15, 3013 for inappropriately used power strips. The unit secretary will initial daily for compliance. Findings will be reported to director or charge nurse. The individual not meeting standard will be counseled and perform a corrective action plan. The charge nurse and TCU Director will do visual spot check on the unit with daily rounds and remove any poser strips used inappropriately. The TCU QA Committee will address and evaluate any issues with power strips used inappropriately on a quarterly basis. The next meeting occurs April 2013. 	
-------	--	-------	---	--

