

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

PRINTED: 10/29/2015
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 R 10/29/2015
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 000}	INITIAL COMMENTS An on-site Revisit Survey conducted in conjunction with Abbreviated Survey KY #23955 on 10/27-29/15 determined the facility was in compliance on 10/02/15, as alleged in the acceptable POC. Abbreviated Survey KY #23955 was unsubstantiated with no deficiencies cited.	{F 000}			

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

TITLE

(X8) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207, and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185272	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 10/29/2015
Name of Facility MCCRACKEN NURSING AND REHABILITATION CENTER		Street Address, City, State, Zip Code 867 MCGUIRE AVE. PADUCAH, KY 42001

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0315</u> Reg. # <u>483.25(d)</u> LSC _____	Correction Completed <u>10/02/2015</u>	ID Prefix <u>F0371</u> Reg. # <u>483.35(l)</u> LSC _____	Correction Completed <u>10/02/2015</u>	ID Prefix <u>F0441</u> Reg. # <u>483.65</u> LSC _____	Correction Completed <u>10/02/2015</u>
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency _____	Reviewed By <u>[Signature]</u>	Date: <u>10/29/15</u>	Signature of Surveyor: <u>[Signature]</u>	Date: <u>10/29/15</u>
Reviewed By _____ CMS RO _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>8/28/2015</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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	INITIAL COMMENTS	F 000			
F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to provide a safe, comfortable environment to help prevent the development and transmission of disease and infection for one (1) of fifteen (15) sampled residents (Resident #3). Certified Nurse Aide (CNA) #3 double gloved when providing incontinent care for Resident #3 and failed to wash her hands after she had provided incontinent care, and prior to applying</p>	F 315	<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 the 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 (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 timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p> <p>F 315</p> <p>1.) C.N.A # 3 was re-educated on 08/27/15 per the Director of Nursing regarding proper incontinent care.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: V. Edward Foley TITLE: Unit Administrator (X5) DATE: 09/24/15

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F 315	<p>Continued From page 1 the resident's barrier cream.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Perineal Care", dated 2005, revealed staff should remove gloves and wash hands before touching clean clothing or linens. Gloves worn while performing perineal care are considered contaminated. There was no reference to double gloving in the facility's policy.</p> <p>Record review revealed the facility admitted Resident #3 on 07/01/12, with diagnoses which included Urinary Tract Infection, Neurogenic Bladder, Cerebrovascular Accident, and Paraplegia.</p> <p>Review of Physician's Orders, dated 08/17/15, revealed Resident #3 was being treated for a Urinary Tract Infection (UTI) with Macroclantin (antibiotic) 100 milligrams (mg) orally (po) every night (HS).</p> <p>Observation of CNA #3 providing incontinent care to Resident #3, on 08/27/15 at 10:48 AM, revealed CNA #3 put on two (2) pair of gloves (one on top of the other). Further observation revealed CNA #3 provided incontinent care, took off one (1) pair of gloves and left one (1) pair on, then put another pair of gloves on over the first pair. CNA #3 then applied barrier cream to the resident's buttock and perineal area. The CNA did not wash her hands in between the incontinent care and applying the barrier cream.</p> <p>Interview with CNA #3, on 08/27/15 at 1:25 PM, revealed she always double gloves, for her safety. She stated her gloved hands were clean</p>	F 315	<p>There was no identified negative outcome noted for R-3.</p> <p>2.) All residents being provided perineal care by nursing staff could potentially be negatively impacted by this deficient practice. Return demonstrations of perineal care are being conducted per the Director of Nursing, Assistant Director of Nursing and Unit Managers by all facility C.N.A's, with no C.N.A.'s working after 09/30/15 without having this re-education.</p> <p>3.) All facility C.N.A's will be re-educated on the proper perineal care procedure with no C.N.A's working after 09/30/15 without having this re-education., these return demonstrations of perineal care are being conducted per the Director of Nursing, Assistant Director of Nursing, and Unit Managers. All new C.N.A's will be educated on this subject upon hire during the orientation process, per the Director of Nursing, Assistant Director of Nursing. And Unit Managers with return demonstrations being conducted.</p> <p>4.) The Director of Nursing, Assistant Director of Nursing and Unit Managers will conduct (5) five return demonstrations of C.N.A's performing perineal care monthly for three months to ensure the procedure is being done properly. The Director of Nursing is responsible to monitor this process. The results of these observations</p>		

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F 315	Continued From page 2 when going from the back side (buttock area) to the front side. She stated she received training during her orientation at the facility; however, she could provide no explanation as to why she cleaned from the back side to the front side. Interview with Licensed Practical Nurse (LPN) #1, on 08/27/15 at 1:20 PM, revealed she would do the front side first and then the back side. LPN #1 stated she would wash her hands after providing incontinent care and change her gloves before doing the buttock area. Interview with Registered Nurse (RN) #1, on 08/27/15 at 1:23 PM, revealed the facility guidelines would be to apply gloves, clean the front side first and then the buttock area, then remove gloves, wash hands, and apply another pair of gloves, then apply the barrier cream to the front side and then the back side (buttock area). RN #1 further stated staff should not double glove.	F 315	will be reviewed with the Quality Assurance Committee monthly for three months. 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 Director of Nursing, Assistant Director of Nursing, Dietary Service Manager, Maintenance Director, Activity Director, Business Office Manager, Administrator with the Medical Director attending at least quarterly.	10/02/15
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	F 371	F 371 1.) The range hood over the stove in the kitchen has had the peeling paint and rust colored debris removed and cleaned and a new coat of paint applied per the facility vendor Premier Fire and Safety, on 09/15/15. 2.) The range hood over the stove in the kitchen has been audited per facility Maintenance Director and found to be free of any rust colored debris or peeling paint on 09/16/15. 3.) Dietary Manager has been re-educated per facility Administrator on 09/18/15, regarding the importance of advising the Administrator of needed repairs in the kitchen immediately. 4.) Dietary Manager will audit the range hood over the stove in the kitchen monthly to ensure there is	

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F 371	<p>Continued From page 3</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observations of the kitchen, revealed multiple areas of peeling paint and brown and rust-colored debris on the inside of the range hood, over the stove.</p> <p>Review of the facility's Census and Condition, dated 08/26/15, revealed there were seventy-three (73) residents in the facility; and, three (3) of these residents were tube feeders and did not consume food items prepared in the kitchen.</p> <p>The findings include:</p> <p>Interview with the Dietary Manager, on 08/28/15 at 8:15 AM, revealed there was no specific policy or cleaning assignment sheet for cleaning the range hood.</p> <p>Observation of the kitchen, on 08/26/15 at 11:20 AM, revealed there was peeling paint, and brown and rust-colored debris covering the inside of the range hood, over the stove.</p> <p>Further interview with the Dietary Manager, on 08/28/15 at 8:15 AM, revealed he was aware of</p>	F 371	<p>no peeling paint or any rust colored debris covering the inside of the hood. The Dietary Manager is responsible to monitor this process. The results of these audits will be reviewed with the Quality Assurance Committee monthly. 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 Director of Nursing, Assistant Director of Nursing, Dietary Service Manager, Maintenance Director, Activity Director, Business Office Manager, Administrator with the Medical Director attending at least quarterly.</p> <p>F 441</p> <ol style="list-style-type: none"> 1.) The soiled bedpan noted in room 104 was discarded. The bedpan in room 105 and the leg bag were discarded. The bed pans in room 108 were discarded. All these items were discarded on 08/26/15 per nursing staff under the direction of the Unit Manager. 2.) All resident rooms have been audited per nursing staff for any unclean bed pans and leg bags on 09/23/15 to ensure that none were found. This was done under the supervision of the Director of Nursing. 3.) All Nursing staff will be re-educated per the Director of Nursing, 	10/02/15	

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F 371	Continued From page 4 problems regarding the peeling paint and debris covering the inside of the range hood, but he had not completed a work order to have this corrected. He revealed there was a company who serviced and cleaned the range hood every six (6) months; however, this company did not do the stripping or painting. Interview with the Interim Administrator, on 08/25/15 at 2:30 PM, revealed he had recently been made aware of the concerns regarding the peeling paint and debris covering the inside of the range hood, and stated the problem would be corrected.	F 371	Assistant Director of Nursing , Unit Managers on ensuring that leg bags and bed pans are labeled, cleaned and stored properly, with no nursing staff working after 09/30/15 without having this re-education. All new nursing staff will be educated on this subject upon hire during the orientation process per the Director of Nursing or Assistant Director of Nursing or Unit Manager.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	4.) The Assistant Director of Nursing, Unit Managers, as well as MDS Nurses, Business Office Manager, Activity Director, Human Resource Director, Medical Records Designee and Social Service Director will audit resident rooms to ensure that bed pans and leg bags are labeled and stored properly at least three times per week . The Director of Nursing is responsible to monitor this process. The results of these audits will be reviewed with the Quality Assurance Committee monthly for three months. Any times concerns are identified the Quality Assurance Committee will convene and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Dietary Service Manager, Maintenance Director, Activity Director, Business Office Manager, and Administrator with the Medical Director attending at least quarterly.	10/03/15

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F 441	<p>Continued From page 5</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility policy review, and review of the facility's Lippincott's Textbook for Nursing Assistants (ninth edition), it was determined the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of infection. Observation during initial tour revealed the facility failed to label, clean, and store bedpans and a leg drainage bag, properly after use.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Infection Control Tracking and Trending Policy and Procedure", last revised 09/13, revealed the purpose was to prevent the spread of infection and provide appropriate education for staff and</p>	F 441			

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F 441	<p>Continued From page 6</p> <p>residents concerning infection control. Further review revealed hand washing, clinical equipment disinfecting, and isolation guidelines were included and intended to meet standards of CDC guidelines for long term care.</p> <p>Review of the facility's Lippincott's Textbook for Nursing Assistants (ninth edition), page 429, under "Assisting a person with using a bedpan", revealed staff should clean equipment and return it to the storage area.</p> <p>Observation during the initial tour, on 08/26/15 at 8:14 AM, revealed a soiled bedpan in the bathroom of resident room #104. The bedpan was noted to be unlabeled and not bagged. Further observation revealed the bathroom for resident room #105 contained two (2) soiled bedpans; and, a leg bag containing a small amount of yellow liquid on a shelf, each being unlabeled and not bagged. In addition, observation revealed the bathroom for resident room #108 had two (2) soiled bedpans unlabeled and not bagged on the floor.</p> <p>Interview with Certified Nurse Aide (CNA) #4, on 08/26/15 at 1:35 PM, revealed bedpans were to be labeled with the resident's names, cleaned out after each use and stored in a bag off the floor. CNA #4 stated the leg bags should be emptied of urine, rinsed out with water, and stored in a bag in the resident's bathroom.</p> <p>Interview with Registered Nurse (RN) #1, on 08/26/15 at 2:20 PM, revealed she expected for bedpans to be labeled with the resident's name, cleaned after each use and placed in a bag off the floor. RN #1 stated the leg bags were to be cleaned out and stored in bags while not in use to</p>	F 441			

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F 441	Continued From page 7 prevent the spread of infection and contamination. Interview with the Director of Nursing (DON), on 08/28/15 at 8:10 AM, revealed she expected the staff to ensure bedpans and leg bags were labeled, cleaned after each use and properly stored in bags off the floor.	F 441			

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{K 000}	INITIAL COMMENTS An on-site Revisit Survey conducted on 10/27/15 determined the facility was in compliance on 10/02/15, as alleged in the acceptable POC.	{K 000}			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185272	(Y2) Multiple Construction A. Building 01 - MAIN BUILDING 01 B. Wing	(Y3) Date of Revisit 10/27/2015
Name of Facility MCCRACKEN NURSING AND REHABILITATION CENTER		Street Address, City, State, Zip Code 867 MCGUIRE AVE. PADUCAH, KY 42001

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0025	Correction Completed 10/02/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0027	Correction Completed 10/02/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0062	Correction Completed 10/02/2015
ID Prefix _____ Reg. # NFPA 101 LSC K0072	Correction Completed 10/02/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0075	Correction Completed 10/02/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0143	Correction Completed 10/02/2015
ID Prefix _____ Reg. # NFPA 101 LSC K0147	Correction Completed 10/02/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <i>DAH/afef</i>	Date: 10/29/15	Signature of Surveyor: <i>Gary Bush, LSC/afef</i>	Date: 10/29/15
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 8/27/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/14/2015
FORM APPROVED
OMB NO. 0938-0391

#693 P.002/024

09/24/2015 15:45

1 270 443 6211

From: MCCRACKEN CO NURSE REHAB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2015
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 K 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG K 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1970.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1970, and upgraded in 1999 with 35 smoke detectors and 2 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry and wet sprinkler system installed in 1970 and upgraded in 2012.</p> <p>GENERATOR: Type II generator installed in 1980. Fuel source is Natural Gas.</p> <p>A Recertification Life Safety Code Survey was conducted on 08/26/15 and 08/27/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred three (103) beds with a census of seventy-three (73) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>		<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 the 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 (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 timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p> <p>K 025</p> <p>1.) The wire chase was closed on both sides of the smoke barrier located on 200 hall per facility vendor Faughn</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE V. Edward Foley TITLE Intervenor Administrator (X6) DATE 09/24/15

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
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PRINTED: 09/14/2015
FORM APPROVED
OMB NO. 0938-0391

#693 P. 003/024

09/24/2015 15:45

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From: MCCRACKEN CO NURSE REHAB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B WING _____	(X3) DATE SURVEY COMPLETED 08/27/2015
NAME OF PROVIDER OR SUPPLIER MCCRACKEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000	Electric on 09/18/15. The pipe located in the attic of 100 hall has had the penetration sealed per Maintenance Director with 3M fire caulk on 09/14/15. The wire chase located in the laundry hall smoke barrier was closed per facility vendor Faughn Electric on 09/18/15.	
K 025 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect five (5) of five (5) smoke compartments, one-hundred three (103) residents, staff and visitors. The facility has the capacity for one-hundred three (103) beds and at the time of the survey, the census was seventy-three (73). The findings include: 1. Observation, on 08/26/15 at 11:47 AM, with the	K 025	2.) Facility maintenance staff has completed an audit of each smoke barrier on 09/18/15 and did not identify any smoke barriers that did not resist the passage of smoke between smoke compartments. 3.) Maintenance Director re-educated by facility Administrator on 09/21/15 in regards to ensuring that each smoke barrier are maintained in order to resist the passage of smoke between smoke compartments. 4.) Maintenance Director will inspect each smoke barriers monthly for (3) three months to ensure they are maintained in order to resist the passage of smoke between smoke compartments. The results of these audits will be forwarded to the Quality Assurance Committee monthly for (3) months for further recommendations. If at any time concerns are identified, the Quality Assurance Committee will consist of at least a minimum the Director of Nursing, Assistant Director of Nursing, Dietary Service Manager, Maintenance Director, Activity Director, Business Office Manager, Administrator with the	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2015
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)
K 025	<p>Continued From page 2</p> <p>Maintenance Director revealed an open electrical wire chase penetrating the smoke barrier located in 200 Hall. The wire chase was open on both sides of the barrier preventing the barrier from resisting the passage of smoke.</p> <p>Interview, on 08/26/15 at 11:48 PM, with the Maintenance Director revealed he was not aware of the open electrical wire chase.</p> <p>2. Observation, on 08/26/15 at 11:55 AM, with the Maintenance Director revealed an unsealed penetration around a pipe located in the attic of 100 Hall.</p> <p>Interview, on 08/26/15 at 11:56 AM, with the Maintenance Director revealed he was not aware of the unsealed penetration.</p> <p>3. Observation, on 08/26/15 at 12:16 PM, with the Maintenance Director revealed an open electrical wire chase penetrating the smoke barrier located in Laundry Hall smoke barrier. The wire chase was open on both sides of the barrier preventing the barrier from resisting the passage of smoke.</p> <p>Interview, on 08/26/15 at 12:17 PM, with the Maintenance Director revealed he was not aware of the open electrical wire chase.</p> <p>The census of seventy-three (73) was verified by the Administrator on 08/27/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/27/15.</p> <p>Actual NFPA Standard:</p>	K 025	<p>Medical Director attending at least quarterly.</p> <p style="text-align: right;">10/02/15</p>

#693 P.004/024

09/24/2015 15:45

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From : MCCRACKEN CO NURSE REHAB

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

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NAME OF PROVIDER OR SUPPLIER MCCRACKEN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 025	<p>Continued From page 3</p> <p>Reference: NFPA 101 (2000 Edition).19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.</p> <p>Reference: NFPA 101 (2000 Edition) 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration</p>	K 025		
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09/24/2015 15:46
1 270 443 6211
From: MCCRACKEN CO NURSE REHAB

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PRINTED: 09/14/2015
FORM APPROVED
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#693 P. 006/024

09/24/2015 15:46

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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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K 025	Continued From page 4 into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose. NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 025	K 027 1.) The coordinating device located on the 200 hall cross corridor will be removed per Maintenance Director on 10/01/15 to ensure the doors close completely, with fire rated door sweeps being installed on the door edges to prevent the passage of smoke at that time. The coordinating device located on the 100 hall cross corridor doors will be removed per Maintenance Director on 10/01/15 to ensure the doors close completely, with fire rated door sweeps being installed on the door edges to prevent the passage of smoke at that time. 2.) Facility Maintenance staff has completed an audit of each set of cross corridor doors located throughout the facility on 09/18/15 and did not identify any that did not close properly. 3.) Facility Maintenance Director re-educated by facility Administrator on 09/21/15 in regards to ensuring that all cross corridor doors close properly. 4.) Maintenance Director will inspect each set of cross coordinator doors located throughout the facility monthly for three months to ensure that they close properly. The results of this audits will be forwarded to	
K 027 SS=E		K 027		

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PRINTED: 09/14/2015
FORM APPROVED
OMB NO. 0938-0391

#693 P. 007/024

09/24/2015 15:46

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From: MCCRACKEN CO NURSE REHAB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2015
NAME OF PROVIDER OR SUPPLIER MCCRACKEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 887 MCGUIRE AVE. PADUCAH, KY 42001	
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K 027	<p>Continued From page 5</p> <p>determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect three (3) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred three (103) beds and at the time of the survey, the census was seventy-three (73).</p> <p>The findings include:</p> <p>1. Observation, on 08/26/15 at 3:18 PM, with the Maintenance Director revealed the cross-corridor doors located in the 200 Hall would not close completely when tested due to the coordinating device not being adjusted properly.</p> <p>Interview, on 08/26/15 at 3:19 PM, with the Maintenance Director revealed he was not aware the door was not closing completely.</p> <p>2. Observation, on 08/26/15 at 3:38 PM, with the Maintenance Director revealed the cross-corridor doors located in the 100 Hall would not close completely when tested due to the coordinating device not being adjusted properly.</p> <p>Interview, on 08/26/15 at 3:39 PM, with the Maintenance Director revealed he was not aware the door was not closing completely.</p> <p>The census of seventy-three (73) was verified by the Administrator on 08/27/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/27/15.</p>	K 027	<p>the Quality Assurance Committee monthly for (3) three 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 a at minimum the Director of Nursing , Assistant Director of Nursing, Dietary Service Director , Maintenance Director, Activity Director, Business Office Manager, Administrator with the Medical Director attending at least quarterly.</p>	10/02/15

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OMB NO. 0938-0391

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09/24/2015 15:46

1 270 443 6211

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2015
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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K 027	Continued From page 6 Actual NFPA Standard: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors. Reference: NFPA 101 (2000 edition), 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke. Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested	K 027	K 062 1.) The blow in type insulation accumulated on the sprinklers in attic above the wing # 3 side was removed by Maintenance Director on 09/22/15. The blow in type insulation on the sprinklers in attic above the 200 hall was removed by Maintenance Director on 09/22/15. The storage was removed from being within 18 inches of the sprinkler head located in the closet of room -310 per Maintenance Director on 08/27/15. The storage was removed from being within 18 inches of the sprinkler head located in the therapy closet per Maintenance Director on 08/27/15. The three sprinkler heads installed on the ceiling of the of the front porch have been removed of the dust and dirt by the Maintenance Director on 09/22/15. The storage was removed from being 18 inches of the sprinkler head located in the medical records storage room by room 217 on 09/14/15 per the Maintenance Director. 2.) Facility Maintenance staff has completed an audit of all sprinkler heads throughout the facility to ensure that are free of obstruction , dust or dirt or any substance on 09/21/15 and did not identify any.	
K 062 SS=E		K 062		

#693 P.009/024

09/24/2015 15:47

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From: MCCRACKEN CO NURSE REHAB

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

PRINTED: 09/14/2015
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2015
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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K 062	Continued From page 7 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 and interview, it was determined the facility failed to ensure the sprinklers were maintained, in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice has the potential to affect four (4) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred three (103) beds and at the time of the survey, the census was seventy-three (73). According to CMS S&C 13-55-LSC the enforcement Implication would be a fully sprinklered facility with minor problems. The findings include: 1. Observation, on 08/26/15 at 11:31 AM, with the Maintenance Director revealed the sprinklers installed in attic above the Wing #3 Side Exit were obstructed from developing a full spray pattern by blow-in type insulation accumulating on the sprinkler heads. Interview, on 08/26/15 at 11:32 AM, with the Maintenance Director revealed he was not aware the insulation was accumulating on the sprinkler heads in the attic. 2. Observation, on 08/26/15 at 11:51 AM, with the Maintenance Director revealed the sprinklers installed in attic above the 200 Hall were obstructed from developing a full spray pattern by blow-in type insulation accumulating on the	K 062	3.) Maintenance Director re-educated by facility Administrator on 09/21/15 on ensuring sprinkler heads are maintained in accordance with National Fire Protection Association (NFPA) standards. 4.) Maintenance Director will inspect sprinkler heads throughout the facility monthly for three months to ensure that they are free of obstruction or dust and dirt or any substance. The results of these audits will be forwarded to the Quality Assurance Committee monthly for three 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 Director of Nursing, Assistant Director of Nursing, Dietary Service Director, Maintenance Director, Activity Director, Business Office Manager, Administrator with the Medical Director attending at least quarterly.	10/03/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2015
NAME OF PROVIDER OR SUPPLIER MCCRACKEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	<p>Continued From page 8 sprinkler heads.</p> <p>Interview, on 08/26/15 at 11:52 AM, with the Maintenance Director revealed he was not aware the insulation was accumulating on the sprinkler heads in the attic.</p> <p>3. Observation, on 08/26/15 at 3:02 PM, with the Maintenance Director revealed storage within eighteen (18) inches of the sprinkler head located in the closet of Room #310.</p> <p>Interview, on 08/26/15 at 3:03 PM, with the Maintenance Director revealed he was not aware of the storage in the closet.</p> <p>4. Observation, on 08/26/15 at 3:10 PM, with the Maintenance Director revealed storage within eighteen (18) inches of the sprinkler head located in the Therapy Closet.</p> <p>Interview, on 08/26/15 at 3:11 PM, with the Maintenance Director revealed he was not aware of the storage in the closet.</p> <p>5. Observation, on 08/26/15 at 3:15 PM, with the Maintenance Director revealed three (3) sprinkler heads installed on the ceiling of the Front Porch were dust and dirt loaded.</p> <p>Interview, on 08/26/15 at 3:16 PM, with the Maintenance Director revealed he was in the process of cleaning the Front Porch.</p> <p>6. Observation, on 08/27/15 at 8:40 AM, with the Maintenance Director revealed storage within eighteen (18) inches of the sprinkler head located in the Medical Records Storage Room by Room #217.</p>	K 062		

#693 P.010/024

09/24/2015 15:47

1 270 443 6211

From: MCCRACKEN CO NURSE REHAB

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PRINTED: 09/14/2015
FORM APPROVED
OMB NO. 0938-0391

#693 P. 0111/024

09/24/2015 15:47

1 270 443 6211

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2015
NAME OF PROVIDER OR SUPPLIER MCCRACKEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	<p>Continued From page 9</p> <p>Interview, on 08/27/15 at 8:41 AM, with the Maintenance Director revealed he was not aware of the storage in the closet.</p> <p>The census of seventy-three (73) was verified by the Administrator on 08/27/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/27/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 13 (1999 Edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>6-1.1.5* Sprinkler piping or hangers shall not be used to support non-system components.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 6-6.5.1.2 Positioning of Sprinklers to Avoid</p>	K 062		

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PRINTED: 09/14/2015
FORM APPROVED
OMB NO. 0938-0391

#693 P. 012/024

09/24/2015 15:48

1 270 443 6211

From: MCCRACKEN CO NURSE REHAB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2015
NAME OF PROVIDER OR SUPPLIER MCCRACKEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 10 Obstructions to Discharge (SSU/SSP) Maximum Allowable Distance Distance from Sprinklers to of Deflector above Bottom of Side of Obstruction (A) Obstruction (in.) (B) Less than 1 ft 0 1 ft to less than 1 ft 6 in. 21/2 1 ft 6 in. to less than 2 ft 31/2 2 ft to less than 2 ft 6 in. 51/2 2 ft 6 in. to less than 3 ft 71/2 3 ft to less than 3 ft 6 in. 91/2 3 ft 6 in. to less than 4 ft 12 4 ft to less than 4 ft 6 in. 14 4 ft 6 in. to less than 5 ft 161/2 5 ft and greater 18 For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall. Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.	K 062	K072 1.) The medication carts are no longer being stored in the egress path by the 200 and 300 hall nurses stations but in a designated area located off the egress path. The medicine carts are no longer being stored in the egress path by the 100 hall nurse station, but in a designated area located off the egress path. The lift and blood pressure machine are no longer being stored in the egress path on the 100 hall , but in a designated area located off the egress path. 2.) Facility Maintenance Director and Administrator have removed all equipment off egress paths on 09/18/15. 3.) Maintenance Director and licensed Nurses re-educated by facility Administrator on 09/21/15 on ensuring that egress paths remain free of all equipment. 4.) Maintenance Director will audit all egress paths monthly for three months to ensure that they are free of equipment. The results of these audits will be forwarded to the Quality Assurance Committee monthly for three months. If at any time , concerns are identified, the Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant	K 072		

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PRINTED: 09/14/2015
FORM APPROVED
OMB NO. 0938-0391

#693 P. 013/024

09/24/2015 15:48

1 270 443 6211

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2015
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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
K 072	Continued From page 11 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 access in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect three (3) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred three (103) beds and at the time of the survey, the census was seventy-three (73). The findings include: 1. Observation, on 08/26/15 at 11:45 AM, with the Maintenance Director revealed medicine carts were being stored in the egress path by the 200 and 300 Hall Nurse Station. Interview, on 08/26/15 at 11:46 AM, with the Maintenance Director revealed the items were routinely stored in this location. 2. Observation, on 08/26/15 at 11:53 AM, with the Maintenance Director revealed medicine carts were being stored in the egress path by the 100 Hall Nurse Station. Interview, on 08/26/15 at 11:54 AM, with the Maintenance Director revealed the items were routinely stored in this location.	K 072	Nursing , Dietary Service Director, Maintenance Director , Activity Director, Business Office Manager , Administrator with the Medical Director attending at least quarterly.	10/03/15

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PRINTED: 09/14/2015
FORM APPROVED
OMB NO. 0938-0391

#693 P.014/024

09/24/2015 15:48

1 270 443 6211

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2015
NAME OF PROVIDER OR SUPPLIER MCCRACKEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 12 3. Observation, on 08/26/15 at 11:55 AM, with the Maintenance Director revealed the storage of a lift and a blood pressure machine was plugged for charging in the egress path of the 100 Hall. Interview, on 08/26/15 at 11:56 AM, with the Maintenance Director revealed the items were routinely stored in this location. The census of seventy-three (73) was verified by the Administrator on 08/27/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/27/15. Actual NFPA Standard: 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. Reference: NFPA 101 (200 Edition) 7.3.2* Measurement of Means of Egress. The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration. Exception: Projections not more than 31/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below. Reference: S&C-12-21-LSC NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not	K 072	K 075 1.) The (44) forty four gallon trash container was removed per the Maintenance Director on 08/27/15. 2.) Facility Maintenance staff has completed an audit throughout the facility to ensure no trash collection receptacles exceed (32) thirty two gallons. 3.) Maintenance Director re-educated per facility Administrator 09/21/15 on ensuring that no trash collection receptacles do not exceed (32) thirty two gallons. 4.) Maintenance Director will audit all trash collection receptacles monthly for three months to ensure none exceed (32) thirty two gallons. The results of these audits will be forwarded to the Quality Assurance Committee for three months. 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 Director of Nursing, Assistant Director of Nursing , Dietary Service Director, Maintenance Director , Activity Director, Business Office Manager , Administrator with the Medical Director attending at least quarterly.	10/09/15
K 075 SS=D		K 075		

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PRINTED: 09/14/2015
FORM APPROVED
OMB NO. 0938-0391

#693 P.015/024

09/24/2015 15:48

1 270 443 6211

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2015
NAME OF PROVIDER OR SUPPLIER MCCRACKEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 075	<p>Continued From page 13</p> <p>exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure linen or trash collection receptacles with capacities greater than thirty-two (32) gallon were stored in accordance with National Fire Protection Association (NFPA) standards. The deficient practice had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred three (103) beds and at the time of the survey, the census was seventy-three (73).</p> <p>The findings include:</p> <p>Observation, on 08/26/15 at 3:29 PM, with the Maintenance Director revealed a trash containers with a capacity of forty-four (44) gallons were being stored in the Dining Room.</p> <p>Interview, on 08/26/15 at 3:30 PM, with the Maintenance Director revealed he was not aware of the requirement for trash receptacles with capacities greater than thirty two (32) gallons.</p>	K 075		

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NAME OF PROVIDER OR SUPPLIER MCCRACKEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 075	Continued From page 14 The census of seventy-three (73) was verified by the Administrator on 08/27/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/27/15. Actual NFPA Standard: Reference: NFPA 101 (2000 Edition) 19.7.5.5 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft ² (20.4 L/m ²). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft ² (5.9-m ²) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. Exception: Container size and density shall not be limited in hazardous areas. NFPA 101 LIFE SAFETY CODE STANDARD	K 075	K 143 1.) C.N. A was re-educated regarding the proper procedure to transfer oxygen per facility Administrator on 08/27/15. 2.) The oxygen transferring room has been audited per Maintenance Director to ensure gloves and face protection are in place. 3.) All C.N.A 's will be re-educated regarding the proper procedure to transfer oxygen per the Director of Nursing , Assistant Director of Nursing and Unit Managers, with no C.N.A's working after 09/30/15 without having this re-education. All new C.N.A's will be trained upon this task during the orientation process, per the Director of Nursing or Assistant Director of Nursing. 4.) Director of Nursing, Assistant Director of Nursing or Unit Managers will observe five C.N.A's transfer oxygen monthly for three months to ensure the procedure is done correctly. The results of these observations will be forwarded to the Quality Assurance Committee monthly for three 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 Director of	
K 143 SS=D	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the	K 143		

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NAME OF PROVIDER OR SUPPLIER MCCRACKEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 857 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 143	<p>Continued From page 15</p> <p>Immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and competency review, it was determined the facility failed to transfer liquid oxygen in accordance with National Fire Protection Association (NFPA) requirements. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred three (103) beds and at the time of the survey, the census was seventy-three (73).</p> <p>The findings include:</p> <p>Observation, on 08/27/15 at 8:17 AM, with the Maintenance Director revealed a Certified Nurse Aide (CNA) holding the door to the oxygen transfilling room open with her foot while she performed transfilling of oxygen with one (1) hand. Further observation revealed the CNA did not put on the gloves or face shield that were located in the transfilling room.</p> <p>Interview, on 08/27/15 at 8:18 AM with the CNA revealed she was performing the task as she was trained.</p> <p>Review of the Clinical Competency Validation checklist, on 08/27/15 at 8:19 AM, with the</p>	K 143	<p>Nursing, Assistant Director of Nursing, Dietary Service Director, Maintenance Director, Activity Director, Business Office Manager, Administrator with the Medical Director attending at least quarterly.</p>	10/02/15

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NAME OF PROVIDER OR SUPPLIER MCCRACKEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 143	<p>Continued From page 16</p> <p>Regional Nursing Director revealed closing the door and wearing the gloves and face protection was included in the training for staff that performs oxygen transfilling.</p> <p>The census of seventy-three (73) was verified by the Administrator on 08/27/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/27/15.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>8-6.2.6.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and</p> <p>b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and</p> <p>c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.</p> <p>Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures.</p> <p>The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.</p>	K 143		

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PRINTED: 09/14/2015
FORM APPROVED
OMB NO. 0938-0391

#693 P. 019/024

09/24/2015 15:49

1 270 443 6211

From: MCKRACKEN CO NURSE REHAB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2015
NAME OF PROVIDER OR SUPPLIER MCCRACKEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 887 MCGUIRE AVE. PADUCAH, KY 42001		
(X4) ID PREFIX TAG K 147 SS=F	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG K 147	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>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 National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility has the capacity for one-hundred three (103) beds and at the time of the survey, the census was seventy-three (73).</p> <p>The findings include:</p> <p>Observation, on 08/26/15 at 11:33 AM, with the Maintenance Director revealed the transfer switch and electrical panels located in the Transfer Switch Room were obstructed by a Hoyer Lift stored in front of the electrical panels.</p> <p>Interview, on 08/26/15 at 11:34 AM, with the Maintenance Director revealed he was aware of the requirements for the spaces around electrical panels and the room was scheduled to be cleaned out later that day.</p> <p>Observation, on 08/26/15 at 12:01 PM, with the Maintenance Director revealed a power strip with a Underwriters Laboratories (UL) listing of ULPS664 was in use under bed A to power personal electronics. The facility did not have a</p>			<p>K -147</p> <ol style="list-style-type: none"> 1.) The hoier lift was removed from the transfer switch room per Maintenance Director on 08/27/15. The power strip was removed under Bed A per Maintenance Director on 08/27/15. The power strip attached to the wall in room 313 was removed on 09/18/15 per the Maintenance Director. The power strip in room 107 was removed per the Maintenance Director on 08/27/15. 2.) Facility Maintenance staff has completed an audit of power strips on 09/23/15 throughout the facility to ensure that CMS approved power strips are being utilized, as well as electrical panels throughout the facility to ensure that they are free of obstructions. 3.) Maintenance Director re-educated per facility Administrator on 09/21/15 on ensuring that power strips used are CMS approved and electrical panels are not obstructed. 4.) Maintenance Director will inspect all power strips and electrical panels monthly for three months to ensure that power strips are CMS approved and electrical panels are not obstructed. The results of these 	

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PRINTED: 09/14/2015
FORM APPROVED
OMB NO. 0938-0391

#693 P.020/024

09/24/2015 15:50

1 270 443 6211

From: MCCRACKEN CO NURSE REHAB

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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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K 147	<p>Continued From page 18</p> <p>waiver in place to use power strips in patient care areas.</p> <p>Interview, on 08/26/15 at 12:02 PM, with the Maintenance Director revealed the facility was in the process of replacing the power strips with CMS approved power strips; however, he was not aware the facility needed a waiver.</p> <p>Observation, on 08/26/15 at 2:57 PM, with the Maintenance Director revealed a power strip was attached to the wall located in Room #313 to replace permanent wiring.</p> <p>Interview, on 08/26/15 at 2:58 PM, with the Maintenance Director revealed he was in the process of removing any power strip attached to the wall.</p> <p>Observation, on 08/27/15 at 8:56 AM, with the Maintenance Director revealed a resident bed was plugged into an unapproved power strip located in Room #107. The facility did not have a waiver in place to use power strips in patient care areas.</p> <p>Interview, on 08/27/15 at 8:57 AM, with the Maintenance Director revealed the facility was in the process of replacing the power strips with CMS approved power strips; however, he was not aware the facility needed a waiver.</p> <p>The census of fifty-six (56) was verified by the Administrator on 05/20/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/20/15.</p> <p>Actual NFPA Standard:</p>	K 147	<p>audits will be forwarded to the Quality Assurance Committee monthly for three 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 Director of Nursing, Assistant Director of Nursing, Dietary Service Director, Maintenance Director, Activity Director, Business Office Manager, Administrator with the Medical Director attending at least quarterly.</p>	10/02/15

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/14/2015
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 01 - MAIN BUILDING 01 B WING _____	(X3) DATE SURVEY COMPLETED 08/27/2015
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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K 147	Continued From page 19 Reference: NFPA 70 (1999 edition) 110-26. Spaces 10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed. Table 110.26(A)(1) Working Spaces Nominal Voltage to Ground Minimum Clear Distance Condition 1 Condition 2 Condition 3 0-150 900 mm (3 ft) 900 mm (3 ft) 900 mm (3 ft) 151-600 900 mm (3 ft) 1 m (3½ ft) 1.2 m (4 ft) Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or	K 147		

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K 147	Continued From page 20 other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts. Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded. Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between. (a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided. (b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc. (c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation. (2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm	K 147			

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K 147	Continued From page 21 (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. (3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment. (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded. (C) Entrance to Working Space. (1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment. (2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met. (a) Unobstructed Exit. Where the location permits a continuous and unobstructed way of exit travel, a single entrance to the working space shall be	K 147			

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K 147	Continued From page 22 permitted. (b) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition. (D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for switched receptacles. In electrical equipment rooms, the illumination shall not be controlled by automatic means only. Reference: CMS S&C 14-16-LSC	K 147			