

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

PRINTED: 06/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185412	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER LOURDES TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1530 LONE OAK ROAD 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	F 000		
F 281 SS=D	<p>An annual survey was conducted on 06/15-17/10 to determine the facility's compliance with federal regulatory requirements. Deficiencies were cited with the highest scope and severity being a "D".</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure services provided or arranged by the facility met professional standards of quality for one resident (#1), in the selected sample of eight (8) residents, related to the failure to follow a written physician order to discontinue an indwelling (Foley) catheter. Findings include:</p> <p>Resident #1 was admitted to the facility, on 06/07/10, with diagnoses to include Lymphedema and Chronic Venous Insufficiency.</p> <p>A review of Resident #1's admission orders, dated 06/07/10 at 4:20 PM, revealed a printed order to "discontinue the indwelling catheter in the AM and may reinsert if resident unable to void." The orders also had a hand written notation which read, "Foley cath-begln discontinuance protocol in the AM."</p> <p>A review of the facility policy entitled, Bladder Training-Foley Discontinuaunce Protocol, dated May 1995 with a revision date of November 2004, revealed the policy outcome standard as follows:</p>	F 281	<p>In regard to Resident #1, a physicians order was obtained on 06/17/10 to continue the foley catheter and the foley catheter remained in place upon the residents discharge to another skilled nursing facility on 06/21/10. The current protocol for residents admitted with indwelling foley catheters will be followed. All staff will be re-educated and inserviced by the director of nursing and administrator regarding unit protocols with appropriate documentation of such at the staff meeting on July 13, 2010. Current policy and protocols were reviewed with both licensed staff members involved in the care of this resident on 06/17/10 by the director of nursing. The medical record of all patients who are admitted to the unit with an indwelling foley catheter will be audited for compliance with policy by the director of nursing the following day beginning July 6, 2010. Audit information will be shared with quality assurance team for discussion and recommendations at the quarterly meeting.</p>	07/13/10 67/14/10 RWB KB/2.2

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

Kelly Bean

TITLE

Nursing Home Administrator

(X5) DATE

7/13/10

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: 06/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185412	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER LOURDES TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1530 LONE OAK ROAD 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	PROMOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 1</p> <p>"The provision of efficient and effective patient care can be enhanced with specific protocol regarding the discontinuance of Foley Catheters." The guidelines for this protocol included if a patient was admitted with a Foley catheter in place, the need for continued use would be evaluated, and discontinued upon physician's orders.</p> <p>A review of Resident #1's Plan of Care, dated 06/08/10, revealed the problem "Urinary Elimination Altered" and included the use of the catheter. Interventions for this problem included the notation, "Catheter, evaluate need 06/07/10, discontinue Foley catheter in AM, May reinsert if unable to void."</p> <p>A review of Resident #1's clinical record, revealed no documentation to indicate the facility had attempted to discontinue the catheter.</p> <p>Observations of Resident #1, on 06/15/10 at 11:20 AM and 2:45 PM and 06/16/10 at 8:20 AM revealed the resident had an indwelling (Foley) catheter in place draining clear yellow urine.</p> <p>An interview with Registered Nurse (RN) #1, on 06/17/10 at 8:30 AM, revealed RN #1 was the charge nurse for the unit on the night Resident #1 was admitted and had transcribed the admission orders but had not actually provided the care for the resident, on the night of 06/07/10. He revealed if the nurse assigned to the resident had not discontinued the catheter as ordered, then this should have been documented and communicated to the physician.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 06/17/10 at 9:15 AM, revealed LPN #1 was</p>	F 281		

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

PRINTED: 06/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105412	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER LOURDES TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 LONE OAK ROAD 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 281	Continued From page 2 assigned to provide care for Resident #1, on the night of 06/07/10. She stated she had not attempted to remove the catheter the following AM. LPN #1 revealed she had not transcribed the admission orders for Resident #1 and was unaware the catheter was scheduled to be discontinued. An interview with the Director of Nursing (DON), on 06/17/10, revealed she expected the staff to attempt to discontinue the indwelling catheter as ordered and if unable to do so for whatever reason, to document why the physician's order was not followed and to notify the physician of the failure to discontinue the catheter.	F 281		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents with pressure sores received necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing for two residents (#1 and #2), in the selected sample of eight (8) residents. This was related to the failure of the facility to follow	F 314	In regard to resident # 1, skin assessment, wound measurement and description was documented on 06/17/10. The treatment record indicates that the appropriate therapeutic intervention was documented until discharge on 06/21/10. In regard to resident # 2, the daily resident overview and weekly skin condition assessment indicates that skin is clear and remains clear with preventive measures in place. Every resident will have a thorough skin assessment upon admission and appropriate protocol initiated. Daily resident overviews will include skin assessments. Measurements and description will be documented according to policy. All licensed staff will be re-educated and involved by the director of nursing and administrator regarding policy and protocol for skin care which includes daily skin assessments with measurements of wounds at the July 13, 2010 staff meeting. Weekly audits by charge nurses will be conducted of residents identified with skin issues with immediate feedback to staff regarding results via certified e-mail. Audit information will be shared with the quality assurance team for discussion and recommendations.	07/13/2010 07/14/10 KB/RJ



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

PRINTED: 06/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185412	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER LOURDES TRANSITIONAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 LONE OAK ROAD 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 314	<p>Continued From page 3</p> <p>the written policy regarding assessment of pressure sores to include measurements and descriptions of the areas. Findings include:</p> <p>A review of the facility policy entitled, "Skin Care: Protocol for Treatment of Pressure Ulcers", dated 01/1998 with a revision date of 05/2009, revealed the related policy, "Skin Breakdown-Protocol for Prevention and Treatment". The stated purpose of the policy was to promote optimum healing of pressure ulcers using standardized care for each stage. The policy stated the resident's skin was to be inspected on a daily basis with special attention to bony prominences. Under the procedure portion of the policy, it was noted the skin should be assessed a minimum of once daily with the daily skin assessment documented on the Patient Profile. If a pressure ulcer was identified the assessment should be documented initially and daily to include the stage, location, size (to include length, width, and depth in centimeters), drainage, odor, description of wound base, presence of undermining or tunneling, and the condition of surrounding skin.</p> <p>1. Resident #1 was admitted to the facility, on 06/07/10, with diagnoses to include Lymphedema and Organic Heart Disease with Chronic Atrial Fibrillation.</p> <p>A review of Resident #1's physician orders, dated 06/08/10 at 9:00 AM, revealed a form entitled, "Protocol for Prevention and Treatment of Pressure or Heel Ulcers or Skin Breakdown." The form indicated orders from the attending physician for treatment to a Stage I pressure ulcer to Resident #1's coccyx area. The treatment order was "Mepilex border dressing every three</p>	F 314		

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

PRINTED: 06/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185412	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2010	
NAME OF PROVIDER OR SUPPLIER LOURDES TRANSITIONAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1530 LONE OAK ROAD 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 314	<p>Continued From page 4</p> <p>days and as needed (prn) to the coccyx to help protect the intact skin. The pressure ulcer should be evaluated daily by gently pulling back the Mepilex and assessing the wound, then gently press Mepilex back into place".</p> <p>A review of Resident #1's Plan of Care, dated 06/08/10, for the problem, "Pressure Ulcers, risk for. ", included a statement under the heading of interventions, "Pressure Ulcer----Stage I, 06/08/10, Apply Mepilex to coccyx every three days when needed."</p> <p>A review of Resident #1's Nursing Admission Evaluation/Care Plan, dated 06/07/10 at 9:00 PM, revealed a body audit was completed and no reddened area was observed to the coccyx or buttocks.</p> <p>A review of Resident #1's Daily Resident Overview forms, dated 06/08-15/10, revealed the first documentation of any skin issues occurred 06/10/10 at 2:00 PM, as "sheer to buttocks." On 06/11/10 at 8:45 PM, the Resident Overview form noted, "Mepilex intact to coccyx." Mepilex was noted to coccyx again 06/12/10 at 9:30 AM and 8:30 PM. On 06/15/10 at 10:30 AM it was noted, "Mepilex to coccyx, sheer present," and on 06/15/10 at 11:45 PM, Mepilex was again noted applied to the resident's coccyx. A review of all Resident Overview forms from 06/08-15/10 revealed no documented descriptions or measurements of the area to Resident #1's coccyx.</p> <p>Interviews with the Director of Nursing (DON), on 06/16/10 at 8:45 AM and 06/17/10 at 10:30 AM, revealed no evidence of an assessment of Resident #1's Stage I pressure ulcer. The DON</p>	F 314		

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

PRINTED: 06/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186412	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER LOURDES TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1530 LONE OAK ROAD 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 314	<p>Continued From page 5</p> <p>stated staff were trained on hire and through annual inservices to assess pressure ulcers every day and document the description of the area, surrounding skin, and measurements of the area.</p> <p>An interview with Registered Nurse (RN) #5/Charge Nurse, on 06/16/10 at 9:00 AM, revealed when a resident was admitted to the long term care unit staff were trained to assess any wound on the resident's body. The assessment included measurements, redness, drainage, surrounding skin, and odor. The "Protocol for Prevention and Treatment of Pressure or Heel Ulcers or Skin Breakdown" would then be implemented and the area would be assessed twice daily.</p> <p>An interview with RN #1, on 06/17/10 at 8:30 AM, revealed he completed Resident #1's Nursing Admission Evaluation/Care Plan when the resident arrived on the long term care unit and he did not recall any skin breakdown present on the resident's coccyx. RN #1 stated if an area was present, the nurse was supposed to be assess and the assessment information documented would include size, depth, color, drainage, and odor. He stated as a practice, he did not assess Stage I areas on a daily basis, but completed a weekly skin assessment, which included measurements and description of the area. RN #1 stated all licensed staff completed an annual inservice regarding pressure ulcers, but he was unsure whether the inservice provided guidance on assessment of the area to include measurements.</p> <p>A review of the weekly skin assessment list revealed Resident #1 was scheduled for a weekly skin assessment, on 06/09/10 on the night shift.</p>	F 314		

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

PRINTED: 06/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185412	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER LOURDES TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 LONE OAK ROAD 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 314	<p>Continued From page 6</p> <p>Review of the clinical record revealed no documented evidence the skin assessment was completed.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 06/17/10 at 9:15 AM, revealed LPN #1 was assigned to provide care for Resident #1 on the night the weekly skin assessment was scheduled. LPN #1 stated she had not completed the skin assessment. She stated she was unaware of the weekly skin assessment schedule and only completed skin assessments when instructed to do so by the charge nurse. LPN #1 revealed she had completed an annual inservice on pressure ulcers and the inservice included guidance on how to assess a pressure area.</p> <p>An interview with RN #2, on 06/17/10 at 10:00 AM, revealed she completed an annual inservice on pressure ulcers, but she was unsure of the content related to assessment of pressure ulcers. RN #2 stated she had not measured Stage I pressure areas.</p> <p>A review of the annual inservice entitled, "Pressure Ulcer Prevention for RN/LPN", revealed skin inspection should occur by the nurse every shift and documentation of pressure ulcers should include the stage of the pressure ulcer, location, size, wound base, granulation, necrotic tissue, exudate (drainage), wound edges, undermining, and tunneling.</p> <p>An observation of Resident #1, on 06/16/10 at 1:50 PM, revealed a nine and one half (9 and 1/2) by ten and one half (10 and 1/2) centimeter, dark reddened area to the coccyx. RN #3 conducted the assessment of the area and identified the area as a Stage I pressure area.</p>	F 314		

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

PRINTED: 06/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185412	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2010	
NAME OF PROVIDER OR SUPPLIER LOURDES TRANSITIONAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1530 LONE OAK ROAD 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 314	<p>Continued From page 7</p> <p>2. Resident #2 was admitted to the facility, on 06/04/10, with the diagnoses to include Syncope, Abdominal Pain and Gastritis.</p> <p>A review of the Nursing Admission Evaluation/Care plan, dated 06/04/10 at 2:45 PM, revealed Resident #2 was admitted with a small eraser size opening to the tip of the rectum. No evidence of measurements were documented.</p> <p>A review of the MDS, dated 06/08/10, revealed Resident #2 had one (1) Stage I and one (1) Stage II pressure area. A review of the Nursing Progress Record, dated 06/06/10 through 06/07/10, revealed no documented evidence of the assessment and/or the measurements the facility policy required.</p> <p>A review of the Physician's Orders, dated 06/04/10 at 3:45 PM, revealed the resident had a Stage I pressure sore to the coccyx and to apply "Mepilex Border dressing (protective barrier) every three days and PRN (as needed to the coccyx), to protect the intact skin. Evaluate daily by gently peeling the dressing and assess the wound; then press dressing back into place".</p> <p>A review of the Daily Resident Overview, dated 06/05/10 at 12:00 PM through 06/07/10 at 9:30 AM, revealed no assessment of the wound or measurements of the opened area at the top of the rectum. On 06/08/10 at 11:20 PM, 06/09/10 at 12:30 PM, 06/10/10 at 11:20 AM and 11:00 PM, revealed the licensed staff charted "Mepilex to bottom". No measurements or assessment of the area were documented.</p> <p>A review of the Treatment Record, dated</p>	F 314		

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

PRINTED: 06/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186412	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2010
NAME OF PROVIDER OR SUPPLIER LOURDES TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 LONE OAK ROAD 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 314	Continued From page 8 06/04/10 at 5:00 PM, revealed the licensed staff were supposed to place Mepilex to the resident's coccyx every third day and PRN. However, there was no documented evidence of an assessment and measurement of the area on the coccyx. An interview with RN #3, on 06/16/10 at 3:00 PM, revealed she could not remember placing the Mepilex dressing on the coccyx of Resident #2 and she had never measured the area.	F 314			

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

PRINTED: 06/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185412	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/16/2010
NAME OF PROVIDER OR SUPPLIER LOURDES TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1530 LONE OAK ROAD 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 A Life Safety Code survey was initiated and conducted on 06/16/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	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.

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185412	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/16/2010
NAME OF PROVIDER OR SUPPLIER LOURDES TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1530 LONE OAK ROAD 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 A Life Safety Code survey was initiated and conducted on 06/16/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	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.