

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

PRINTED: 01/29/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  189134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/14/2015
NAME OF PROVIDER OR SUPPLIER  HAZARD HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE HAZARD, KY 41702		
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F 000	INITIAL COMMENTS	F 000		
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility policy it was determined the facility failed to ensure services were provided in accordance with each resident's written plan of care for one (1) of three (3) sampled residents (Resident #1). A review of Resident #1's comprehensive care plan revealed the resident required extensive assistance of two staff members for transfers. On 12/24/14, facility staff failed to transfer the resident with two people. One staff person attempted to transfer the resident and the resident fell.</p> <p>The findings include: A review of the facility's policy titled Care Plan Policy and Protocol, dated August 2012, revealed staff would develop a comprehensive care plan for each resident to meet a resident's medical, nursing, mental, and psychosocial needs, which had been identified in the resident's comprehensive assessment. The policy stated</p>	F 282	(SEE ATTACHED)	2-18-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Charlotte C. Shensberry RN MSN* TITLE *Administrator* DATE *2/6/15*

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.

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F 282	<p>Continued From page 1</p> <p>the Kardex would be utilized as a guide for Nurse Aides in providing resident care on a daily basis.</p> <p>A review of the facility's policy titled Resident Status Kardex, not dated, revealed the resident's Kardex was used to ensure appropriate care was provided for facility residents. The policy stated Licensed Nurses verbally reported the information on the Kardex to facility Nurse Aides. In addition, Nurse Aides were responsible for reviewing the Kardex to ensure appropriate care was delivered to facility residents.</p> <p>A review of the medical record for Resident #1 revealed the facility admitted the resident on 01/14/14 with diagnoses that included Diabetes, Hypertension, and Chronic Airway Obstruction. A review of the resident's annual Minimum Data Set (MDS) assessment dated 12/23/14 revealed the resident required extensive assistance of two staff members with transferring and ambulation. In addition, staff assessed the resident to be interviewable with a Brief Interview for Mental Status (BIMS) score of 15.</p> <p>Resident #1 was discharged from the facility due to an acute hospital stay, and was unable to be interviewed.</p> <p>A review of Resident #1's Kardex (not dated) and Comprehensive Care Plan last reviewed and revised on 12/30/14 revealed the resident required extensive assistance of two staff members for transferring and ambulation.</p> <p>A review of Resident #1's incident report dated 12/24/14 revealed the resident fell when being transferred to the bedside commode with one staff member's assistance. Further review</p>	F 282			

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F 282	<p>Continued From page 2</p> <p>revealed the resident had not sustained any major injuries because of the fall.</p> <p>State Registered Nurse Aide (SRNA) #4, who transferred Resident #1 when the fall occurred on 12/24/14, was no longer employed at the facility and was unable to be reached for an interview on 01/14/15.</p> <p>An interview with Registered Nurse (RN) #1 on 01/14/15 at 3:15 PM revealed she completed the incident report for Resident #1 when the fall occurred on 12/24/14. The RN stated she identified the causative factor of the fall was that staff (SRNA #4) transferred the resident to the bedside commode without the assistance of two staff members. The RN stated she reads the resident care information on the resident's Kardex to the SRNAs daily during verbal report, and "had just read it to her [SRNA #4] a little bit before the fall occurred." The RN stated the SRNA acknowledged she "should have gotten help" to transfer the resident when the fall occurred on 12/24/14.</p> <p>An interview with the Director of Nursing (DON) on 01/14/15 at 4:30 PM revealed licensed nursing staff provided verbal report daily to all SRNAs. The DON stated the information from each resident's Kardex, which included the number of staff required to transfer/ambulate the resident, was provided to the SRNAs daily. The DON continued to state SRNAs had been trained to look at the Kardex daily to ensure care was provided as required. The DON stated two staff members should have assisted Resident #1, as outlined in the resident's plan of care, when the fall occurred on 12/24/14.</p>	F 282		

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F 323 F 323 SS=D	Continued From page 3 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility's policy it was determined the facility failed to ensure residents received adequate supervision to prevent accidents for one (1) of three (3) sampled residents (Resident #1). A review of Resident #1's medical record revealed staff assessed the resident to require the assistance of two staff members when being transferred. However, on 12/24/14 Resident #1 fell when one staff member assisted the resident with transferring, instead of two persons as required by the resident's plan of care.  The findings include:  A review of the facility's policy titled "Fall Prevention Program," not dated, revealed staff would identify residents who were at high risk for falls and implement safety measures to limit or eliminate risks for facility residents.  A review of the medical record for Resident #1 revealed the facility admitted the resident on 01/14/14 with diagnoses of Diabetes, Hypertension, and Chronic Airway Obstruction. A	F 323 F 323	(SEE ATTACHED)	2-18-15

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F 323	<p>Continued From page 4</p> <p>review of Resident #1's annual Minimum Data Set (MDS) assessment dated 12/23/14 revealed the resident required extensive assistance of two staff members when being transferred. In addition, staff assessed the resident to be interviewable with a Brief Interview for Mental Status (BIMS) score of 15.</p> <p>Resident #1 was discharged from the facility due to an acute hospital stay and was unable to be interviewed during the investigation on 01/14/15.</p> <p>A review of Resident #1's Kardex (not dated) and Comprehensive Care Plan, last reviewed and revised on 12/30/14, revealed staff assessed the resident to be at risk for falls. Continued reviewed revealed the resident required extensive assistance of two staff members when being transferred.</p> <p>A review of Resident #1's incident report dated 12/24/14 revealed the resident had a fall when being transferred to the bedside commode with the assistance of one staff person, not two staff members as outlined in the resident's plan of care.</p> <p>An interview was attempted on 01/14/15 with State Registered Nurse Aide (SRNA) #4, who transferred Resident #1 when the fall occurred on 12/24/14. However, the SRNA was no longer employed at the facility and was unable to be reached for an interview.</p> <p>An interview with Registered Nurse (RN) #1 on 01/14/15 at 3:15 PM revealed she had completed the incident report for Resident #1 when the fall occurred on 12/24/14. The RN confirmed Resident #1 required the assistance of two staff</p>	F 323			

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F 323	<p>Continued From page 5</p> <p>members to be safely transferred. The RN stated she had identified the causative factor of the fall to be that staff (SRNA #4) transferred the resident to the bedside commode without the assistance of two staff members. The RN stated that prior to the resident's fall on 12/24/14, the RN provided the SRNA the information from the resident's Kardex regarding how Resident #1 was to be safely transferred. The RN stated the SRNA acknowledged when the fall occurred that she "should have gotten help" before she transferred the resident on 12/24/14.</p> <p>An interview with the Director of Nursing (DON) on 01/14/15 at 4:30 PM revealed licensed nursing staff provided verbal report daily to all SRNAs. The DON stated the information from the resident's Kardex, which included the number of staff required to safely transfer a resident, was provided to the SRNAs daily. The DON stated SRNAs had been trained to look at the Kardex daily to ensure care was provided safely as required. The DON further stated two staff members should have assisted Resident #1 as outlined in the resident's plan of care when the fall occurred on 12/24/14.</p>	F 323			