

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

PRINTED: 07/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/03/2012
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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE, P O BOX 1329 HAZARD, KY 41702
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 282	<p>Continued From page 1</p> <p>Review of the medical record for Resident #2 revealed a Comprehensive Care Plan dated 04/12/12. According to the care plan, Resident #2 required the assistance of two staff members, with the use of a port-a-lift for all transfers.</p> <p>A review of the Kardex (a list of care and interventions for the residents) for Resident #2 (undated) revealed all transfers for Resident #2 were to be made by two staff members and a port-a-lift.</p> <p>A review of an incident report dated 06/13/12, revealed two CNAs transferred Resident #2 without a lift as required for the resident and the resident sustained a non-injurious fall.</p> <p>CNAs #11 and #12 acknowledged in interview conducted on 07/02/12, at 2:50 PM, and 07/03/12, at 11:30 AM, that they were aware Resident #2's plan of care required two staff members to utilize a lift for Resident #2 with transfers but the CNAs stated they did not utilize the lift for Resident #2 on 06/13/12, at 8:00 PM, because Resident #2 disliked the lift and the CNAs felt they could safely transfer without the use of the lift. The CNAs stated during the transfer the resident could not bear weight and the CNAs sat the resident down on the floor beside the bed. According to CNA #11 and CNA #12, they notified nursing staff that the resident fell and stated the nurses assessed the resident and found no injuries. CNAs #11 and #12 acknowledged they were counseled by the facility after the incident and were both terminated from the facility related to not transferring Resident #2 in accordance with the resident's plan of care.</p>	F 282		
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F 282	<p>Continued From page 2</p> <p>Interviews with RN #1 and LPN #1 on 07/03/12, at 1:30 PM and 1:50 PM, revealed resident care issues are addressed in their plan of care and on the Kardex located at the nurses' station. The nurses stated care issues included in the care plans and Kardex included assistive devices required for safe transfers and other special interventions required for the residents. According to the interview, Resident #2's plan of care and Kardex indicated the resident required the use of a port-a-lift with at least two staff members for safe transfers.</p> <p>Interview with the Director of Nursing (DON) and the Administrator on 07/03/12, at 3:05 PM, revealed identified care needs were listed on each resident's plan of care and the Kardex which was utilized by nurses to give report to the CNAs. The DON and the Administrator stated Resident #2 required the use of a port-a-lift with at least two staff members and that the incident that occurred on 06/13/12, had been investigated. According to the Administrator and the DON, the facility's investigation revealed CNAs #11 and #12 did not utilize the port-a-lift as noted in the plan of care and the Kardex and as a result CNA #11 and CNA #12 were counseled and terminated from the facility.</p>	F 282		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p>	F 323	(SEE ATTACHED)	7-23-12

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F 323	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policies, it was determined the facility failed to provide adequate supervision to prevent accidents for one of four sampled residents (Resident #2). Resident #2 was assessed to require a port-a-lift with the assistance of two staff members; however, on 06/13/12, Resident #2 was transferred without the use of a port-a-lift and sustained a non-injurious fall.</p> <p>The findings include:</p> <p>Review of the Falls Prevention Program (undated) revealed residents at high risk for falls would have interventions in place to reduce the risk of falls, and all staff would be in-serviced on the proper techniques for such interventions.</p> <p>Review of the medical record for Resident #2 revealed staff had assessed Resident #2 and noted on an annual Minimum Data Set (MDS) dated 04/12/12, that Resident #2 required the assistance of two staff members with a lift for all safe transfers. Interventions listed on a Comprehensive Care Plan dated 04/12/12, also revealed Resident #2 required the assistance of two staff members with the use of a port-a-lift for all transfers.</p> <p>A review of the Kardex (a tool utilized by nurses to give report to CNAs of care and interventions for the residents) for Resident #2 (undated)</p>	F 323		

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F 323	<p>Continued From page 4</p> <p>revealed all transfers for Resident #2 were to be made by two staff members and a port-a-lift.</p> <p>Review of the facility incident report revealed on 06/13/12, two Certified Nursing Assistants (CNAs) transferred Resident #2 without a lift as required and the resident sustained a non-injurious fall.</p> <p>CNAs #11 and #12 acknowledged in interview conducted on 07/02/12, at 2:50 PM, and 07/03/12, at 11:30 AM, they did not utilize the lift for Resident #2 on 06/13/12, at 8:00 PM, because Resident #2 disliked the lift and the CNAs felt they could safely transfer without the use of the lift. The CNAs stated during the transfer the resident could not bear weight and the CNAs sat the resident down on the floor beside the bed. According to CNA #11 and CNA #12, they notified nursing staff that the resident fell and stated the nurses assessed the resident and found no injuries. CNAs #11 and #12 acknowledged they had received in-service training related to proper lift techniques and they knew to utilize a lift with two staff members for Resident #2. A review of in-services and documentation of demonstrations for proper lift techniques dated 05/09/12 and 05/10/12, confirmed CNA #11 and CNA #12 had received in-service training related to lifting techniques. CNA #11 and CNA #12 stated they were counseled by the facility after the incident and were both terminated from the facility related to not transferring Resident #2 with the port-a-lift as required.</p> <p>Interviews with Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1 on 07/03/12, at 1:30 PM and 1:50 PM, revealed all residents have care issues addressed on the Kardex at the</p>	F 323		
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F 323	<p>Continued From page 5</p> <p>nursing station and the CNAs have access to the Kardex. The nurses stated care issues included in the Kardex were assistive devices required, safe transfers, and any special interventions required for the residents. According to the interview, Resident #2 required the use of a port-a-lift with at least two staff members for safe transfers.</p> <p>Interview with the Director of Nursing (DON) and the Administrator on 07/03/12, at 3:05 PM, revealed Nursing Supervisors, as well as LPNs, RNs, MDS Coordinators, and the ADON and DON make rounds at least twice a day as part of a Quality Assurance program and if any problems were identified they were taken care of immediately and in-services were provided as needed. The DON and the Administrator stated resident lifts were checked by the Maintenance Department and were kept in working condition. In addition, the Administrator and the DON stated the residents that required the use of a lift have the information listed on the Kardex, and the Kardex was utilized by nurses to give report to the CNAs coming on duty at the change of shift. The DON and the Administrator stated Resident #2 required the use of a port-a-lift with at least two staff members and that the incident that occurred on 06/13/12, was investigated. According to the Administrator and the DON, the facility's investigation revealed CNAs #11 and #12 did not utilize the port-a-lift as required and as a result CNA #11 and CNA #12 were counseled and terminated from the facility.</p>	F 323		
F 364 SS=D	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides</p>	F 364	(SEE ATTACHED)	7-23-12

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F 364	<p>Continued From page 6</p> <p>food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</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 ensure food was palatable and at the proper temperatures when served to the residents. Observations of the morning meal on 07/03/12, revealed a resident meal tray tested for palatability contained scrambled eggs which tasted cold, biscuit with gravy which tasted cold, sausage which tasted cold, and milk which tasted cool but not cold.</p> <p>The findings include:</p> <p>A review of the facility's policy titled, "Meal Pass," which contained no date, revealed residents' meal delivery would be served timely so that foods were received by residents at appropriate temperatures (cold food to be served at 41 degrees Fahrenheit or below and hot food to be served at 135 degrees Fahrenheit or above).</p> <p>A group interview conducted on 07/03/12, at 12:15 PM, revealed if the residents ate in their bedrooms the food items were cold at times.</p> <p>Observation of the morning meal on the 200 Unit of the facility on 07/03/12, at 8:15 AM, revealed meal trays were delivered to the 200 Unit in an insulated cart. Cold foods were stored on the cart along with hot foods. The last tray to be delivered</p>	F 364		
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F 364	<p>Continued From page 7</p> <p>from the meal cart was intercepted at 8:45 AM (30 minutes after the cart arrived to the Unit), and food temperatures were obtained and a palatability test was conducted with the Dietary Manager (DM). The scrambled eggs were at 94 degrees Fahrenheit and tasted cold; the biscuit with gravy was at 92 degrees Fahrenheit and tasted cold; the sausage was at 88.5 degrees Fahrenheit and tasted cold, and the 2% milk was at 62 degrees Fahrenheit and tasted cool, but not cold.</p> <p>An interview conducted with the DM on 07/03/12, at 8:50 AM, revealed that based on facility practices trays should only be allowed to sit for 20 minutes before being sent back to the kitchen to be replaced. The DM stated she observed meal trays being passed two times per week, had observed the breakfast meal one week prior to the observation, and had not identified any concerns.</p> <p>An interview with State Registered Nursing Assistant (SRNA) #13 on 07/03/12, at 9:05 AM, revealed it usually took 20 to 25 minutes to pass the morning meal trays to residents on the 200 Unit. The SRNA stated trays should be sent back to the kitchen and replaced if sitting on the cart longer than 20 minutes.</p> <p>An interview conducted with the Unit Manager (UM) for the 200 Unit on 07/03/12, at 9:20 AM, revealed staff was expected to notify her when trays could not be served timely, and would be expected to send meal trays back to the kitchen to be replaced if they sat on the tray cart for longer than 20 minutes.</p>	F 364		
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F 364	Continued From page 8 An interview with the Director of Nursing (DON) on 07/03/12, at 3:00 PM, revealed SRNAs were expected to notify the UM if meal trays could not be passed to the residents timely so the trays could be sent back to the kitchen for replacement. The DON also stated the DM was responsible for meal tray audits and to her knowledge, the facility had not identified any issues.	F 364		

Hazard Health and Rehabilitation Center
Plan of Correction
July 23, 2012

F 282

1. Resident # 2 is being transferred with the assistance of two staff members and a port-a-lift as assessed in accordance with the written plan of care.
2. All residents were reviewed and re-assessed to determine the proper amount of assistance and/or port-a-lift required for transfers. The written plan of care and Kardex of each resident has been reviewed to ensure accuracy. These tasks were completed on June 14 and 15, 2012. No irregularities were found.
3. In-servicing began that evening on July 13, 2012 by Pat Webb, RN, 3-11 Supervisor and continued (conducted by Nursing Supervisors) with all nursing employees prior to their next scheduled shift. The in-services were completed by June 22, 2012. The in-service stressed giving and getting report by the Kardex. It also stressed that the staff was to utilize the Kardex (written plan of care) when providing care. The staff was also educated regarding transfer techniques, including the importance of utilizing the appropriate number of staff or devices required for transferring.
4. The CQI Committee designees will select 1 resident per unit assessed to be transferred per port-a-lift and 1 resident per unit to be assessed to be transferred per 1 or 2 staff members to review the plan of care and Kardex to ensure that the appropriate amount of assistance for transfers has been assessed appropriately. Observations will be conducted on the selected residents to ensure the appropriate number of staff is providing assistance. These audits/observations will be conducted on a weekly basis for eight weeks, then monthly for one quarter. Any identified concerns will be corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: July 23, 2012.

Hazard Health and Rehabilitation Center, Inc
Plan of Correction
July 24, 2012

F 364

1. The trays remaining on the cart after the test tray failed were pulled and new trays were gotten from the Dietary Department.
2. Residents are receiving palatable food trays in a timely manner with food items at appropriate temperatures.
3. An in-service was conducted by the DON and Nursing Supervisors with all nursing staff (beginning on July 2 – 9) regarding the importance of timely removal from the delivery carts and presentation of food trays during meal service. It was stressed that if trays are not presented to the resident within 20 minutes of the food cart arrival, the tray cards are removed, those trays returned to the kitchen uneaten and new trays prepared and served to the residents. This in-service took place prior to staffs' next scheduled shift. The Dietary Staff was also in serviced by the Dietary Manager and the Corporate Consultant (July 2 – 6, 2012) regarding the replacing of trays if beyond the acceptable time frame.
4. The CQI Committee designees will perform meal pass audits including all three meals for palatability, correct temperature checks, and timeliness of delivery. The audits will be conducted weekly for one month then monthly for one quarter. Any irregularities will be corrected immediately and reported to the CQI Committee for further review and follow-up.
5. Completion Date: July 23, 2012.

Hazard Health and Rehabilitation Center, Inc
Plan of Correction
July 23, 2012

F 323

1. Resident # 2 is being transferred with the assistance of two staff members and a port-a-lift as assessed per the written plan of care.
2. All residents were reviewed and assessed to determine the proper amount of assistance required for transfers. This was completed on July 13 and 14, 2012. Observations were made of residents that required two or more staff members and/or a port-a-lift to transfer safely. No irregularities were found.
3. An in-service was conducted by Pat Webb, RN, 3-11 Supervisor on the evening shift of June 13, 2012 and then by Nursing Supervisors with all employees prior to their next scheduled shift. These were completed by June 22, 2012. The in-services included transfer techniques and the importance of utilizing the appropriate number of staff or devices required for transfer. It was stressed that the staff was to utilize the Kardex (written plan of care) when providing care.
4. The CQI Committee designees will select one resident per unit assessed to be transferred per port-a-lift and one resident per unit to be assessed to be transferred per one or two staff members to review the plan of care and Kardex to ensure that the appropriate amount of assistance for transfers has been assessed appropriately. Observations will be conducted on the selected residents to ensure the appropriate number of staff is providing assistance. These audits/observations will be conducted weekly basis for eight weeks, then monthly for one quarter. Any identified concerns will be corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: July 23, 2012.