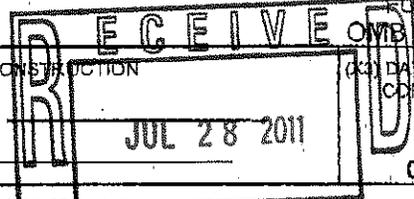


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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185166	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/30/2011
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NAME OF PROVIDER OR SUPPLIER  HARLAN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEDICAL CENTER DRIVE HARLAN, KY 40831 Division of Health Care Southern Employment Branch
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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
F 000	INITIAL COMMENTS	F 000	(See Attachment)	
F 248 SS=E	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure an ongoing program of activities was provided. There was no evidence the facility provided activities on Saturdays to meet residents' needs in accordance with the interests, and the physical, mental, and psychosocial well-being of each resident.</p> <p>The findings include:</p> <p>There was no policy regarding activities provided by the facility.</p> <p>An interview with a group of alert and oriented residents on 06/29/11, at 1:00 PM, revealed the activities that were posted on the activity calendar for Saturdays had not occurred. According to the residents, coffee and doughnuts were delivered to the residents on the snack carts, and a movie was made available to the residents by means of</p>	F 248		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Gail Pace</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/27/11</i>
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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 248	<p>Continued From page 1</p> <p>a television set in each resident room. The residents also stated if a resident had no visits from family members on the weekend the weekends were long and boring.</p> <p>An interview with the Activities Director (AD) on 06/29/11, at 4:00 PM, revealed the AD and the AD Assistant worked Monday through Friday from 8:00 AM until 5:00 PM, and activities were conducted by volunteers and CNAs on the weekends. The AD stated attendance sheets were not marked for activities that occurred on the weekends because neither the AD nor the AD Assistant was present on the weekends to conduct the activities. The AD said the coffee and doughnut activity was carried out by the Dietary Department and stated some residents were not allowed to have doughnuts because of their diets. According to the AD, the movie was started by a CNA in the activity room and was sent by closed-circuit television to all the residents in their rooms.</p> <p>An interview with the Dietary Manager (DM) on 06/29/11, at 4:30 PM, revealed the coffee and doughnut activity had been conducted in the dining room with all the residents present. However, according to the DM, since the facility developed the FISH list (a list of residents who need extra fluids) the doughnuts and coffee were sent out on a snack cart to each resident room at 10:00 AM on Saturdays, for the residents that could have them. Additional snacks were offered to the residents that were on modified diets.</p> <p>Interviews with CNAs #1, #2, and #3, and NA #1 on 06/29/11, at 2:05 PM, 2:10 PM, 2:15 PM, and 2:30 PM, revealed the CNAs did not conduct</p>	F 248			

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F 248	Continued From page 2 activities on weekends with the residents, and did not start movies for residents on weekends.  A review conducted on 06/29/11, of the record of the group programs for the months of May and June 2011 revealed activities had not been marked as having been provided on Saturdays for any resident in the facility.  An interview with the Administrator on 06/29/11, at 5:00 PM, revealed the facility relied on volunteers for weekend activities.	F 248		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide effective housekeeping/maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Several resident rooms were observed to have doors/closet doors that stuck and were difficult to open. Sharp edges were observed on three resident room doors, a headboard was observed to be chipped, and a hole was observed in the wall of resident room 1010. The bed control handle in resident room 300 was observed in the floor underneath the resident's bed.	F 253		

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F 253	<p>Continued From page 3</p> <p>The findings include:</p> <p>Observations made during the environmental tour on 06/30/11, revealed the following:</p> <ul style="list-style-type: none"> <li>-The closet doors in resident rooms 403 and 703 were difficult to open/close.</li> <li>-The entrance door to resident room 705 did not fit the doorframe and was difficult to open/close.</li> <li>-Sharp edges were observed on the entrance doors of resident room doors 703, 909, and 1003.</li> <li>-A hole was observed in the wall next to the bathroom door in resident room 1010.</li> <li>-The headboard of bed 1 in room 909 was observed to be chipped.</li> <li>-The bed control handle in resident room 300 was observed on the floor under the bed. An interview with the resident's family member on 06/29/11, revealed maintenance staff had repaired the handle previously, but the handle continued to fall from the bed.</li> </ul> <p>An interview conducted with the Maintenance Supervisor (MS) during the environmental tour on 06/30/11, revealed staff was to submit work requests to the Maintenance Department for concerns related to maintenance services. The MS stated he checked the requests daily, however, no maintenance requests had been submitted regarding these concerns.</p>	F 253		
F 282 SS=G	<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>	F 282		

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F 282	Continued From page 4  This REQUIREMENT is not met as evidenced by: Based on interview, record review, fall investigation review, and a review of policies and procedures, it was determined the facility failed to ensure services were provided to one of twenty-five sampled residents in accordance with the resident's plan of care (Resident #10). The facility failed to ensure that a care plan intervention for two staff persons to assist Resident #10 with transfers and toileting had been implemented in accordance with the resident's written plan of care. Resident #10 sustained a fall on 02/14/11, when one State Registered Nursing Assistant (SRNA) attempted to transfer the resident from a wheelchair to a standing position. The resident sustained a laceration to the forehead and a right hip fracture.  The findings include:  A review of the Fall Investigation for Resident #10 revealed on 02/14/11, State Registered Nurse Aide (SRNA) #5 assisted Resident #10 in his/her wheelchair to the sink, assisted the resident to stand without waiting for assistance from another staff person as indicated on the Resident's Kardex, and allowed the resident to hold onto the sink with both hands. The Fall Investigation further revealed the wheelchair was positioned directly behind the resident and the wheels on the wheelchair were locked in place. Based on the report, the SRNA attempted to change the resident's incontinence brief, from a standing position, and had reached to obtain and open a trash bag. When Resident #10 leaned to the right, the SRNA was unable to catch the resident,	F 282			

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F 282	<p>Continued From page 5</p> <p>and the resident subsequently fell and struck his/her head on the bed. The Fall Investigation further revealed SRNA #5 stated she had known the resident required two persons for transfer and for toileting.</p> <p>A review of the facility's policy titled, "Resident Status Kardex," (no date) revealed it was the responsibility of the nurse to complete and update the Resident Status Kardex. The policy further revealed it was the responsibility of the SRNA to review the Kardex to ensure appropriate care was delivered to the resident, or if the SRNA had questions that pertained to the delivery of care of the resident. In addition, the policy revealed the Resident Status Kardex reflected the current needs of the resident.</p> <p>A review of the medical record for Resident #10 revealed the resident was admitted to the facility on 02/12/04, with diagnoses that included Dementia, Osteoarthritis, Osteoporosis, and Degenerative Joint Disease.</p> <p>A review of the Fall Risk Assessment completed on 02/08/11, revealed the facility had assessed Resident #10 as a high risk for falls, with a score of 20. According to the assessment, a total score of greater than 10 indicated the resident was at a high risk for falls.</p> <p>A review of a Quarterly Minimum Data Set (MDS) dated 02/08/11, revealed the facility assessed Resident #10 to require the assistance of two persons for transfers and toileting. Resident #10 was also assessed as incontinent of both bladder and bowel. In addition, based on documentation, the facility assessed Resident #10's cognition to</p>	F 282		

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F 282	<p>Continued From page 6 be severely impaired.</p> <p>A review of the resident's care plan, dated 05/26/10 through 03/03/11, revealed Resident #10 had been assessed to have potential for injury. The care plan revealed Resident #10 had risk factors for injury that included an unsteady gait, a history of falls, and decreased mobility. A review of interventions related to the resident's risk for injury included two staff persons to transfer the resident to a wheelchair. In addition, a care plan dated 05/26/10 through 03/03/11, revealed Resident #1 also had been assessed to have a diagnosis of osteopenia, degenerative joint disease in the left foot, and potential for pain and further injury. Interventions related to the care plan revealed two staff persons were to transfer the resident to a wheelchair, and two to three staff persons were to assist the resident with ambulation.</p> <p>A review of the Kardex in use by the SRNAs on 02/14/11, for Resident #10 revealed the resident required the assistance of two persons for toileting and transfers. The Kardex further revealed Resident #10 had been assessed as a high fall risk.</p> <p>A review of the nurse's notes for Resident #10 dated 02/14/11, at 1:45 PM, revealed the nurse had been called to the resident's room by SRNA #5. The nurse's notes revealed Resident #10 had fallen, was lying on the floor, and was observed to have a laceration to the right side of his/her hand. Continued review of the nurse's notes revealed the resident complained of right hip pain. The resident's physician was notified of the fall, and orders were received to transfer the</p>	F 282		

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F 282	<p>Continued From page 7</p> <p>resident to an acute care facility. The resident was diagnosed with a right hip fracture and had a one-half inch laceration to the right forehead that required steri-strips.</p> <p>An interview conducted on 06/30/11, at 9:00 AM, with SRNA #5 revealed the Kardex contained information that pertained to the level of care. The SRNA stated Resident #10 required the assistance of two persons for transfers and toileting. The SRNA stated the facility had adequate staff to provide care required by the residents, but she thought she could change the resident's incontinence brief by herself. The SRNA further stated, "I could have gotten another SRNA to assist with the transfer, but I don't have a reason why I did it by myself."</p> <p>An interview conducted with RN #5 on 06/30/11, at 9:30 AM, revealed she was responsible for the care for Resident #10 on 02/14/11. The RN stated SRNAs were expected to review the Kardex daily to ensure residents received care as assessed in the care plan. The RN also stated she made rounds every two hours to ensure the SRNAs provided care as planned in a written care plan for each resident. RN #5 further stated that on 02/14/11, the SRNA told her that she had attempted to transfer Resident #10 by herself and the resident had fallen. RN #5 informed the Clinical Coordinator of the resident's fall and that the SRNA had transferred the resident without assistance as required by the plan of care.</p> <p>An interview conducted with the Clinical Coordinator (CC) of the Whispering Pines Unit of the facility on 6/30/11, at 10:15 AM, revealed SRNAs were required to review the Kardex at the</p>	F 282		

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F 282	<p>Continued From page 8</p> <p>beginning of their shift to ensure they were aware of and provided care as planned for the residents. The CC further stated nurses were expected to make rounds every two hours to ensure care was provided as planned for residents. The CC also stated she made rounds on a daily basis to ensure care was provided. The CC stated SRNA #5 should not have attempted to transfer without assistance or change the resident's incontinence brief without assistance.</p> <p>Interviews conducted with SRNAs #6 and #7 on 6/30/11, at 1:35 PM and 1:40 PM, revealed information related to the resident's care was contained in the Kardex. The SRNAs also stated they were required to check the Kardex at the beginning of their shift. The SRNAs further stated the facility had provided in-services related to the use of the Kardex. SRNAs #6 and #7 confirmed Resident #10 required the assistance of two staff persons for toileting and for transfers.</p> <p>An interview with the Director of Nursing (DON) on 6/30/11, at 2:30 PM, revealed SRNAs were required to review the Kardex at the beginning of their shift to obtain information related to each resident's care needs. In addition, according to the DON, nurses were required to give SRNAs a verbal report related to each resident's plan of care, and to make rounds every two hours to ensure the appropriate level of care was being provided to the residents. The DON further revealed the CCs made rounds on a daily basis. The DON stated SRNA #5 should have waited for assistance to help with the provision of Resident #10's planned care needs. The DON provided documentation of an in-service provided by the facility on Kardexes held on 12/22/10. Based on</p>	F 282		
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F 282	Continued From page 9 documentation, SRNA #5 attended the in-service on 12/22/10.	F 282		
F 323 SS=G	<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> <p>This REQUIREMENT is not met as evidenced by: Based on interview and a review of records, the facility's fall investigation, hospital records, and policies, it was determined the facility failed to ensure one of twenty-five sampled residents (Resident #10) received adequate supervision and assistance to prevent accidents. Resident #10 was assessed to be at a high risk for falls; and required two staff persons for safe transfers and toileting. The facility failed to ensure transfers were performed safely to prevent accidents/injuries to Resident #10. On 02/14/11, one staff person attempted to transfer Resident #10 in order to change the resident's incontinence brief. During the transfer, Resident #10 sustained a fall which resulted in a laceration to the forehead and a nondisplaced fracture of the right hip.</p> <p>The findings include:</p> <p>The Fall Investigation for Resident #1 revealed on 02/14/11, State Registered Nurse Aide (SRNA)</p>	F 323		

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F 323	<p>Continued From page 10</p> <p>#5 assisted Resident #10 to the sink in a wheelchair. SRNA #5 assisted Resident #10 to stand without waiting for assistance for assistance from another staff person, while the resident held onto the sink with both hands. The SRNA attempted to change the resident's incontinence brief while the resident was in a standing position. Based on the report, when the SRNA reached to obtain and open a trash bag, Resident #10 leaned to the right, the SRNA was unable to catch the resident, and the resident fell and struck his/her head on the bed. The Fall Investigation revealed SRNA #5 was aware the resident required two persons for transfer and for toileting.</p> <p>A review of the facility's Falls Prevention Program policy (no date) revealed staff was required to assess all residents for fall risk upon admission and with any change in condition, utilizing the Fall Risk Assessment Form. According to the policy, the resident's Kardex would be "flagged" to signify the resident was at high risk for falls.</p> <p>A review of the medical record for Resident #10 revealed the resident's diagnoses at the time of admission on 02/12/04, included Dementia, Osteoarthritis, Osteoporosis, and Degenerative Joint Disease. The Fall Risk Assessment completed on 02/08/11, revealed the facility assessed Resident #10 as a high risk for falls, with a score of 20 which indicated the resident was at a high risk for falls. Based on the Quarterly Minimum Data Set (MDS) dated 02/08/11, the facility assessed Resident #10 to require the assistance of two persons for transfers/toileting and was assessed to be incontinent of both bladder and bowel. In</p>	F 323		

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F 323	<p>Continued From page 11</p> <p>addition, based on documentation, the facility assessed Resident #10's cognition to be severely impaired.</p> <p>A review of Resident #10's care plan, dated 05/26/10 through 03/03/11, revealed facility staff had identified "problem" areas related to the resident's care that included the resident's diagnoses of osteopenia, degenerative joint disease in the left foot, potential for pain, and potential for injury/further injury. The care plan revealed resident #10 had risk factors for injury that included an unsteady gait, a history of falls, and decreased mobility. A review of interventions listed on the care plan revealed two staff persons were to assist the resident when the resident was transferred to a wheelchair and two to three staff persons were to assist the resident with ambulation.</p> <p>The Kardex for Resident #10 utilized by staff on 02/14/11, revealed the resident had been assessed to require the assistance of two persons for toileting/transfers and had been "flagged" to indicate the resident was a high risk for falls.</p> <p>A review of the nurse's notes for Resident #10 dated 02/14/11, at 1:45 PM, revealed the nurse was called to the room by State Registered Nursing Assistant (SRNA) #5. According to the nurse's notes Resident #10 had fallen and was lying on the floor with a laceration observed on the right side of the resident's head. Resident #10 was also complaining of right hip pain. The physician was notified and orders were received for Resident #10 to be transported to an acute care facility.</p>	F 323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185166	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  06/30/2011
NAME OF PROVIDER OR SUPPLIER  HARLAN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEDICAL CENTER DRIVE HARLAN, KY 40831		
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F 323	<p>Continued From page 12</p> <p>A review of the Emergency Room record for Resident #10 dated 2/14/11, revealed the resident had a one-half inch laceration to the right forehead and a right hip fracture. The resident required hospitalization from 02/14/11 until 02/17/11, for these injuries.</p> <p>The Discharge Summary from the acute care facility dated 02/17/11, revealed Resident #10 had sustained a right intertrochanteric (hip) nondisplaced fracture, and was assessed by the orthopedic surgeon who requested only symptomatic treatment be provided for the resident's hip fracture. According to the discharge summary the resident was to be discharged back to the nursing facility with Physical Therapy and Occupational Therapy provided.</p> <p>An interview conducted on 06/30/11, at 9:00 AM, with SRNA #5 revealed the Kardex contained information regarding the type of care that each resident had been assessed to require. The SRNA acknowledged Resident #10 required the assistance of two persons for transfers and toileting. The SRNA stated the facility had adequate staff to provide care required by the residents, but she thought she could change the resident's incontinence brief by herself.</p> <p>An interview conducted with RN #5 on 06/30/11, at 9:30 AM, revealed the RN was responsible for the care of Resident #10 on 02/14/11. According to the RN, the SRNAs were responsible to review the Kardex at the beginning of every shift to ensure residents received care as required on the plan of care. The RN reported making rounds at</p>	F 323			

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F 323	<p>Continued From page 13</p> <p>least every two hours to ensure the SRNAs provided care as planned for each resident. RN #5 stated the SRNA informed the RN on 02/14/11, that the SRNA had had attempted to transfer Resident #10 without the assistance of additional staff and the resident had fallen. The RN informed the Clinical Coordinator of the incident.</p> <p>An interview with the Clinical Coordinator (CC) on 6/30/11, at 10:15 AM, revealed the SRNAs were required to review the Kardex at the beginning of every shift to ensure they were aware of and provided care as planned for the residents. According to the CC, nurses were required to make rounds at least every two hours, and the CC was responsible to make rounds on a daily basis to ensure care was provided as required by the plan of care. The CC stated the SRNA should have obtained assistance from another staff person prior to transferring Resident #10.</p> <p>Interviews conducted with SRNAs #6 and #7 on 06/30/11, at 1:35 PM and 1:40 PM, revealed SRNAs were required to review the Kardex at the beginning of every shift. The SRNAs stated the facility provided in-services related to the use of the Kardex and that Resident #10 required the assistance of two staff persons for toileting and for transfers.</p> <p>The Director of Nursing (DON) stated in interview on 06/30/11, at 2:30 PM, the SRNAs were required to review the Kardex at the beginning of every shift to obtain information related to each resident's care needs and to check for any changes that had been added. According to the DON, nurses were required to give the SRNAs a</p>	F 323		

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F 323	Continued From page 14 verbal report related to each resident's plan of care every shift and to make rounds at least every two hours to ensure the appropriate level of care was provided to the residents. The DON stated SRNA #5 should have waited for assistance to help with the provision of Resident #10's planned care needs.	F 323		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431		

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F 431	<p>Continued From page 15</p> <p>package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide pharmaceutical services to ensure out-of-date biologicals were not available for resident use. In the Rosewood Unit's medication room there were forty-three blood culture tubes that were out of date and available for resident use.</p> <p>The findings include:</p> <p>Observation on 06/30/11, of the Rosewood medication storage room revealed two boxes of blood culture tubes available for resident use that had an expiration date of 05/31/11:</p> <p>An interview with the unit charge nurse, Registered Nurse (RN) #6, conducted on 06/30/11, revealed the staff did not use the blood culture tubes very often.</p> <p>An interview with the Registered Nurse Clinical Manager, RN #4, on 06/30/11, at 3:25 PM, revealed the staff utilized the blood culture tubes to obtain blood specimens for laboratory studies as ordered by the physician. RN #4 was unaware the blood culture tubes were out of date. RN #4 further stated the unit supervisors were responsible to check medication rooms each Monday, but apparently the expired blood culture tubes were missed.</p>	F 431		

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Harlan Health & Rehabilitation Center  
Annual Survey—June 28-30, 2011  
Plan of Correction

DISCLAIMER: The completion and submission of this plan of correction does not constitute an admission that the facility agrees with the deficiencies as stated in the 2567. The facility is completing the plan of correction as is required by state and federal law. The facility disagrees with and disputes the deficiencies stated in the 2567. Further, it is undisputed that the facility appropriately trained its employees, fully assessed, and care planned accordingly with regards to the only resident example cited in the statement of deficiencies. The resident involved in the example remained a resident at the facility and is fully functioning in all respects. Falls sometimes occur with the residents in long term care facilities despite all precautions being taken. The employee involved and all staff were retrained when the fall occurred in February of this year prior to the cabinet investigating this matter.

F 248

1. Meaningful activities are now being planned and provided on Saturdays.
2. Residents were interviewed to determine what activities they would like on the weekends. Activities are being planned and provided in accordance to the residents' needs and interests.
3. An in-service was conducted with the activities staff by the Administrator on 7/1/11 regarding weekend activities. Activities staff will rotate working half a day on Saturdays to ensure that activities are provided as planned and are meaningful to the residents. Arrangements have been made with Restorative Nursing and/or Dietary staff to provide activities in the event that Activities staff are unavailable.
4. Weekend activities will be monitored every Monday by a CQI Committee member designee through resident interview and review of the attendance roster for one month and then monthly thereafter in resident council to ensure that Saturday activities are being provided as planned and are meaningful. Any irregularities will be reported to the CQI committee and addressed immediately.
5. Completion Date: 7/22/11.

**Harlan Health & Rehabilitation Center  
Annual Survey—June 28-30, 2011  
Plan of Correction**

F 253

1. All environmental and/or maintenance issues identified during the survey have been addressed and corrected.
  - a. The closet doors in resident rooms 403 and 703 were repaired. The Maintenance Supervisor (MS) adjusted the hardware to ensure the doors open and close more easily.
  - b. The entrance door to room 705 was repaired. The MS installed a new hinge. The door fits properly and is now easy to open and close.
  - c. The sharp edges that were observed on the doors of rooms 703, 909 and 1003 have been repaired. The MS trimmed and smoothed any sharp edges and installed screws to secure the door plates.
  - d. The hole in room 1010 has been patched and painted.
  - e. A new headboard was ordered and installed to replace the chipped headboard identified.
  - f. The bed control handle in room 300 has been replaced and is functioning properly.
2. A thorough environmental round was made by the Administrator, Maintenance Supervisor and Housekeeping Supervisor to identify any other problems and to ensure all environmental issues had been addressed and corrected. All resident areas are safe, functional and sanitary.
3. All staff were in-serviced on 7/05/11 thru 7/22/11 by the Administrator, Administrative Nursing Staff, and Housekeeping Supervisor (HS) on the importance of reporting any environmental or equipment in need of repair/replacement to the MS or HS department utilizing the CQI Referral Form.
4. Thorough rounds in every room will be conducted once a week for one month, then once a month for one quarter by a CQI Committee member designee. Any identified concerns will be reported to the MS and/or the HS and addressed immediately. The CQI Committee will review findings of rounds weekly to ensure all problems have been addressed.
5. Completion Date: 7/22/11

**Harlan Health & Rehabilitation Center, Inc.**  
**Plan of Correction**  
**Annual Survey June 28-30, 2011**

**F282**

1. Resident #10 is being transferred with assistance of two staff members 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 required for transfers. The written plan of care & Kardex of each resident has been reviewed to ensure accuracy. No other irregularities were found.
3. An in-service was conducted by the Administrator and Director of Nursing on July 5, 2011 with all nursing staff, including nurse aides and nurses, on following the plan of care/Kardex when providing care and notifying the nurse or Clinical Coordinator if care needs have changed. The staff were also educated regarding transfer techniques, including the importance of utilizing the appropriate number of staff or devices required for transferring.
4. CQI Committee designee will select 6 charts at random to review care plan 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 are providing assistance. These audits/observations will be conducted on a weekly basis for one month, then monthly for the next quarter. Any identified concern will be corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: July 22, 2011

**Harlan Health & Rehabilitation Center, Inc.**  
**Plan of Correction**  
**Annual Survey June 28-30, 2011**

**F323**

1. Resident #10 is being transferred with assistance of two staff members 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. Observations were made of residents being transferred that require two or more staff members to assist. No other irregularities were found.
3. An in-service was conducted by the Administrator and Director of Nursing on July 5, 2011 with all nursing staff, including nurse aides and nurses, regarding transfer techniques, including the importance of utilizing the appropriate number of staff or devices required for transferring. The staff were also educated on following the plan of care/Kardex when providing care and notifying the nurse or Clinical Coordinator if care needs have changed.
4. CQI Committee designees will conduct 6 random observations per week of residents to ensure the appropriate number of staff are providing assistance. The observations will also include a review of the Kardex to ensure the appropriate amount of assistance was used during the transfer. The audits/observations will be conducted on a weekly basis for one month, then monthly for one quarter. Any identified concern will be corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: July 22, 2011.

Harlan Health & Rehabilitation Center  
Annual Survey—June 28-30, 2011  
Plan of Correction

F 431

1. The out-of-date biologicals, forty-three blood culture tubes, were removed from the Rosewood Place medication storage room immediately and discarded. No residents were directly affected by the out-of-date culture tubes.
2. A complete thorough review of both med rooms and supply rooms were conducted and no other concerns or issues were identified. A review of all lab results performed by lab or nursing personnel at this facility revealed that there were no blood cultures obtained since May 12, 2011. Therefore no residents were affected by the out-of-date blood culture tubes.
3. An in-service was conducted by the Director of Nursing and Nursing Administrator beginning on 7/5/11 for all nurses regarding the importance of checking expiration date on all vacutainers prior to use. The nurse for each unit will monitor, on a bi-monthly basis, the expiration date of all biologicals in the med room. Any items found to be out-of-date will be removed and discarded.
4. A CQI Committee designee member will audit the med rooms on each unit to ensure that out-of-date biologicals are discarded. Bi-monthly audits will be done on each med room for one quarter and then monthly thereafter.
5. Completion Date: 7/22/2011