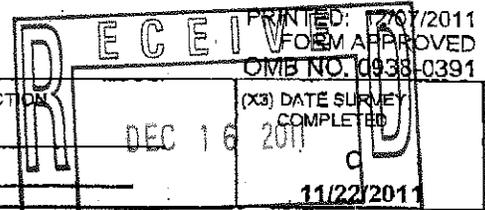


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



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 11/22/2011
NAME OF PROVIDER OR SUPPLIER HARLAN HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEDICAL CENTER HARLAN, KY 40831	

(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 abbreviated standard survey (KY17199) was conducted on 11/21-22/11. The complaint was substantiated with deficient practice identified at "D" level.	F 000	See Attached	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of policies it was determined the facility failed to ensure services were provided in accordance with each resident's plan of care for one of three sampled residents. Facility staff assessed Resident #1 to require the assistance of two staff persons for transfers. However, a facility staff person transferred the resident without assistance on 10/01/11 and Resident #1 sustained a skin tear to the right lower leg. The findings include: A review of the facility policy entitled Resident Status Kardex (undated) revealed it was the responsibility of the State Registered Nurse Aide (SRNA) to review the Kardex to ensure appropriate care was delivered to the resident or when the SRNA had questions regarding the delivery of care. The facility admitted 87-year-old Resident #1 on	F 282		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maile Pace, Administrator TITLE: _____ (X6) DATE: 12/15/11

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.

Received Time Dec. 16. 2011 10:20AM No. 4175

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

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FORM APPROVED
OMB NO. 0938-0391

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F 282	<p>Continued From page 1</p> <p>04/18/11 with diagnoses of Atrial Fibrillation, Osteopenia, Congestive Heart Failure, and Dementia.</p> <p>A review of the comprehensive assessment for Resident #1 dated 08/12/11 revealed the resident required extensive assistance of two staff persons for all transfers. Additional review revealed Resident #1 was assessed to have fragile skin and was at risk for skin tears.</p> <p>A review of the care plan developed for Resident #1 dated 08/18/11 revealed the facility identified that the resident had a potential problem of alteration of the resident's skin integrity related to the requirement for assistance with mobility. A review of the care plan interventions revealed the resident required two staff persons for transfers.</p> <p>A review of the nurse's notes revealed on 10/01/11, at 7:00 PM, while being assisted to bed by staff, Resident #1 hit his/her right lower leg against the wheelchair causing two skin tears. Documentation revealed the resident's physician and responsible party were notified of the incident and orders were received from the physician for treatment of the resident's leg. A review of the facility's investigation of the incident revealed SRNA #1 failed to follow the plan of care developed for Resident #1 and transferred the resident unassisted on 10/01/11.</p> <p>An interview conducted with SRNA #1 on 11/21/11, at 3:25 PM, confirmed the SRNA provided care for the resident on 10/01/11 and transferred the resident from the wheelchair to the bed unassisted. According to SRNA #1, Resident #1 bumped his/her leg on the</p>	F 282			

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F 282 Continued From page 2
wheelchair which resulted in a skin tear to the resident's leg. SRNA #1 stated she immediately reported the incident to the nurse. SRNA #1 acknowledged she was aware of the care plan established for Resident #1 and that two staff persons were to assist the resident with transfers. SRNA #1 stated she had not been feeling well and transferred the resident without considering the need for assistance.

F 282

An interview conducted with Licensed Practical Nurse (LPN) #1 on 11/21/11, at 3:30 PM, revealed the LPN was notified by SRNA #1 on 10/01/11 that Resident #1 bumped his/her leg on the wheelchair during a transfer. The LPN confirmed she notified the resident's physician, responsible party, and completed an incident report.

An interview conducted with the Unit Manager on 11/21/11 revealed SRNAs were required to review each resident's Kardex at the beginning of the shift and were to refer to the care plan if they had questions regarding resident care needs.

F 309
SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

F 309

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

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F 309	<p>Continued From page 3</p> <p>Based on interview, record review, and a review of facility policies, the facility failed to ensure necessary care and services were provided to maintain the highest practicable physical well-being for one of three sampled residents (Resident #1). Documentation revealed facility staff failed to provide care in accordance with the resident's comprehensive assessment and plan of care and the resident sustained a skin tear during a transfer on 10/01/11.</p> <p>The findings include:</p> <p>A review of the facility policy entitled "Transferring the Resident from the chair to the wheelchair or bed" (undated) revealed the policy did not address the number of staff required to transfer residents safely.</p> <p>Resident #1 had been assessed by the facility to have a history of fragile skin and required extensive assistance of two staff persons for all transfers. However, documentation revealed on 10/01/11, at 7:00 PM, one staff person assisted Resident #1 with a transfer and the resident sustained two skin tears to the right lower leg.</p> <p>An interview conducted with State Registered Nurse Aide (SRNA) #1 on 11/21/11, at 3:25 PM, revealed the SRNA provided care to Resident #1 on 10/01/11 and transferred the resident from a wheelchair to the bed without the assistance of another staff person. According to the SRNA, Resident #1's right lower leg "bumped" into the wheelchair and the resident sustained a skin tear. SRNA #1 stated she had reviewed the resident's Kardex and was aware the resident required the assistance of two staff persons for transfers.</p>	F 309		

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F 309	<p>Continued From page 4</p> <p>However, according to SRNA #1, she was "not feeling well" and had transferred the resident unassisted. According to SRNA #1 the resident's nurse was notified of the incident and the resident was assessed and treated by the nurse.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on 11/21/11, at 3:30 PM, confirmed SRNA #1 had informed the LPN that she transferred Resident #1 from the wheelchair to the bed on 10/01/11 without assistance, and the resident bumped his/her right leg on the wheelchair. According to LPN #1, SRNA #1 acknowledged to LPN #1 that she had completed the transfer without the assistance of another staff person and was aware the resident required the assistance of two staff persons.</p> <p>Interview conducted with the Director of Nursing (DON) on 11/21/11, at 6:00 PM, revealed the facility provided in-service training to staff when they were hired, and throughout the year, related to providing care in accordance with the resident's plan of care/Kardex. In addition, the DON stated nursing staff monitored resident care two to three times a day to ensure resident care was provided in accordance with each resident's plan of care.</p>	F 309		

Harlan Health & Rehabilitation Center, Inc.
Plan of Correction
November 22, 2011

F282

1. Resident #1 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 October 3, 2011 and November 22, 2011 with all nursing staff, including nurse aides and charge nurses, on following the plan of care/Kardex when providing care and notifying the charge 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: November 22, 2011

Harlan Health & Rehabilitation Center, Inc.
Plan of Correction
November 22, 2011

F309

1. Resident #1 is receiving the necessary care and services to attain/ maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care.
2. All residents' assessments and plans of care were reviewed to determine the resident was receiving specified care and services as assessed. Particular attention was noted in regard to utilizing the proper amount of assistance required for transfers.
3. An in-service was conducted by the Administrator and Director of Nursing on October 3, 2011 and November 22, 2011 with all nursing staff, including nurse aides and charge nurses, on ensuring that residents are receiving care and services to maintain residents at the highest practicable level of functioning based on assessment and comprehensive care plan. Additionally, in-service included specifics on following the plan of care/Kardex when providing care and notifying the charge 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 care and services are being provided to attain/maintain the residents' highest practicable level of functioning and well being in accordance with the plan of care. Particular focus will be observations of appropriate amount of assistance for transfers to ensure the number of staff to assist 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: November 22, 2011