

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

PRINTED: 08/14/2014
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. _____ AUG 27 2014	(X3) DATE SURVEY COMPLETED C 07/31/2014
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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 399 PARK AVENUE HAZARD, KY 41702 Division of Health Care Southern Enforcement 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
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F 000	INITIAL COMMENTS	F 000		
F 365 SS=D	<p>483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS</p> <p>Each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on closed record review, interview, and facility policy review, it was determined that the facility failed to ensure food was prepared to meet the individual needs of one (1) of three (3) sampled residents, Resident #1. The facility admitted Resident #1 on 07/17/14 with an order to receive a mechanical soft diet with chopped meats. However, on Monday, 07/21/14, four (4) days after the resident's admission to the facility, an interview revealed staff served Resident #1 a regular diet during the evening meal.</p> <p>The findings include: Review of the facility's policy, "Serving Meal Trays" (no date) revealed that staff is to check items on the tray with the dietary card prior to serving the tray and assure that the tray is complete. A review of the facility's "Meal Pass" policy (no date) revealed that staff is to make sure the tray matches the diet card and that both are correct.</p>	F 365	(SEE ATTACHED)	9-5-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Charlotte C. Wynn, RN, MSN</i>	TITLE <i>Administrator</i>	(X8) DATE <i>8/22/14</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 365	<p>Continued From page 1</p> <p>Review of the closed record revealed the facility admitted Resident #1 on 07/17/14 with diagnoses that included Stroke with flaccid Right Hemiparesis and Chronic Obstructive Pulmonary Disorder (COPD). The admission orders revealed the resident was to receive a mechanical soft diet with chopped meats. Continued review of documentation revealed the resident was transferred and readmitted to the hospital four days after his/her admission to the facility.</p> <p>Resident #1 was discharged from the facility on 07/21/14, and was unavailable for observation or interview.</p> <p>An interview with the DON (Director of Nursing) on 07/30/14 at 5:15 PM revealed she received a report from nursing staff on 07/22/14 that Resident #1 had received the wrong tray for dinner on 07/21/14. She stated that she investigated the incident and received a statement from the State Registered Nursing Assistant (SRNA) that had served the tray to Resident #1. According to the DON, the SRNA stated she took a meal tray with a pork chop to the resident, cut the pork chop into small pieces, and began feeding the resident. The DON stated the SRNA reported the resident "pocketed" a piece of pork chop in her mouth and the SRNA realized that the resident was not able to eat the meal. According to the DON, the nurse aide then took the tray to the Charge Nurse and reported to the Charge Nurse that the resident was having trouble with the meal. The DON stated the Charge Nurse checked the resident's diet order in the medical record and realized the resident should have received chopped meats. The DON stated the Charge Nurse returned the tray to the</p>	F 365		
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F 365	<p>Continued From page 2</p> <p>kitchen and obtained the appropriate diet for the resident. The DON stated the SRNA fed Resident #1 the food items from the correct tray and reported the resident had no problems eating the meal.</p> <p>Attempts to contact the SRNA that had fed Resident #1 on 07/21/14 were made by telephone on 07/31/14; however, the attempts were unsuccessful.</p> <p>An interview conducted on 07/30/14 at 4:55 PM with Licensed Practical Nurse (LPN) #1 revealed LPN #1 provided direct care for Resident #1 on 07/17/14, 07/18/14, and 07/21/14 during the 3:00 PM to 11:00 PM shifts. The LPN stated that Resident #1 had not experienced any problems eating or drinking prior to receiving the regular diet meal tray on 07/21/14. The LPN stated that the resident did not actually consume any of the food items from the regular diet meal tray on 07/21/14. LPN #1 stated that when the resident received the mechanically soft diet with chopped meats and pudding thickened liquids, Resident #1 ate it with no signs of choking or problems.</p> <p>An interview was conducted with the Dietary Manager on 07/31/14 at 10:55 AM. She stated that Resident #1 had been admitted to the facility after the last meal had been served on Thursday evening, 07/17/14. The Dietary Manager stated the resident's diet order would not have been entered into the computerized system until Friday morning, 07/18/14. According to the Dietary Manager, the facility was having a fundraiser on 07/31/14 and stated she had been unsure if she had actually entered the resident's diet order into the computerized system; however, the Dietary Manager stated she reviewed the resident's diet</p>	F 365			

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F 365	Continued From page 3 order in the system after she became aware of the incident and the correct diet order was in the system. The Dietary Manager stated she was unsure why the resident received the wrong diet on Monday, 07/21/14, four days after the resident was admitted to the facility.	F 365			

**Hazard Health and Rehabilitation Center
Plan of Correction
August 22, 2014**

F 365

1. Resident # 1 is no longer a resident here at this facility.
2. All residents' diet cards were compared to the diets ordered by the MD orders. All residents' diet cards were correct per the MD orders.
3. An in-service was conducted by the Administrator on July 23, 2014 with the Dietary Manager on ensuring the tray card is correct by the MD order. This was repeated on July 28, 2014 by the RD with the Clinical Dietary Manager and Dietary Manager on the policy & procedure for comparing the diet order against the tray card. Again the dietary staff was in-serviced on ensuring the resident trays match the diet cards. The in-service was conducted on July 28, 2014 by the RD, clinical dietary manager and the dietary manager and repeated by the dietary manager until all dietary staff was in-serviced. The policy for ensuring the tray card matched the MD's diet order was revised to include the dietary manager will print off a copy of what is in the computer and staple it to the Status Change Form (communication slip from Nursing to Dietary) after comparing the two for accuracy. The Nursing Staff (licensed nurses and SRNA's) was in-serviced by the DON and Nursing Supervisors on July 23 & 24, 2014 on the Meal Pass Policy as to comparing the tray to the diet card for correct consistencies, diets, etc.
4. The CQI Committee Designees will perform meal round audits on alternate meals daily for one week then two times weekly for two weeks then one meal weekly for two months. The CQI Committee Designees will monitor the trays coming off the tray line for accuracy daily (alternating meals) for one week, three times weekly for two months. The CQI Committees designees will monitor all orders/tray cards for one month then ten per week for two months. Any irregularities will be corrected immediately and reported to the CQI Committee for further review and follow-up.
5. Completion Date: September 5, 2014.