

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

FORM APPROVAL  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  486134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/13/2015
NAME OF PROVIDER OR SUPPLIER  HAZARD HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE HAZARD, KY 41702		
(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		
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, review of the facility's policy, and review of the facility's investigation, it was determined the facility failed to ensure services were provided in accordance with the written plan of care for one (1) of five (5) sampled residents (Resident #1). The facility assessed Resident #1 to require two (2) staff members with transfers and review of the resident's care plan revealed staff was directed to provide two (2) staff members to transfer the resident. However, on 08/04/15 at approximately 12:15 PM facility staff failed to utilize two (2) staff members to transfer the resident as required and as a result, Resident #1 sustained a fall.</p> <p>The findings include: Review of the facility policy titled "Care Plan Policy and Protocol," last revised August 2012, revealed the "Kardex" would be utilized daily, as a guide for Nurse Aides in providing care to facility</p>	F 282 (SEE ATTACHED)	9-16-15	

RECEIVED  
SEP 11 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Charlotte C. Shamsberry RN, MSN* TITLE *Administrator* DATE *9/11/15*

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 residents.</p> <p>Review of Resident #1's medical record revealed staff admitted the resident on 02/03/98 with diagnoses that included difficulty walking and lack of coordination. Review of the resident's Quarterly Minimum Data Set (MDS) Assessment dated 07/08/15 revealed staff assessed the resident to require the assistance of two (2) staff members when transferred.</p> <p>Review of Resident #1's care plan and "Kardex" revealed the resident was totally dependent on staff for activities of daily living (ADLs) and required the assistance of two (2) staff members for transfers.</p> <p>Review of Resident #1's Incident report dated 08/04/15 revealed the resident experienced a fall when he/she was transferred with the assistance of one (1) staff member, instead of two (2) as outlined in the resident's plan of care.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1 on 08/13/15 at 10:30 AM confirmed she transferred Resident #1 on 08/04/15 without asking for assistance from another staff member. The SRNA stated she knew the resident's care plan stated the resident required two (2) staff members when he/she was transferred. SRNA #1 stated, "I don't know why I didn't get help to transfer" Resident #1, "but I should have."</p> <p>Interview with the Administrator on 08/12/15 at 4:15 PM confirmed staff had been trained to provide resident care, as outlined in the resident's Kardex (plan of care). The Administrator stated SRNAs were required to provide residents with assistance as directed in the resident's plan of</p>	F 282		

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F 282	Continued From page 2 care. She stated staff should have provided Resident #1 with the assistance of two (2) persons when he/she was transferred on 08/04/15 and SRNA #1 was immediately suspended due to the incident.	F 282		
F 323 SS-D	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, review of the facility policy, and a review of the facility's investigation it was determined the facility failed to ensure residents received adequate supervision and assistance to prevent accidents for one (1) of five (5) sampled residents (Resident #1). Resident #1 experienced a fall on 08/04/15, when he/she was transferred with the assistance of one (1) staff member. Review of Resident #1's most recent Minimum Data Set (MDS) Assessment and the resident's current plan of care, revealed the resident was assessed to require the assistance of two (2) staff members for transfers; however, on 08/04/15 one (1) facility staff member assisted Resident #1 to transfer. As a result, Resident #1 fell.  The findings include:	F 323		

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F 323	<p>Continued From page 3</p> <p>Review of the facility policy titled "Falls Prevention Program," not dated, revealed staff was to implement safety measures in an attempt to eliminate a resident's risk for falls.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 02/03/98 with diagnoses of lack of coordination and difficulty walking. Review of the resident's Quarterly Minimum Data Set (MDS) Assessment dated 07/08/15 revealed Resident #1 required the assistance of two (2) staff members when transferred.</p> <p>Review of Resident #1's care plan and "Kardex" revealed Resident #1 was totally dependent on staff for activities of daily living (ADLs) and required the assistance of two (2) staff members for transfers.</p> <p>Review of Resident #1's incident report dated 08/04/15 revealed Resident #1 experienced a fall when he/she was transferred with assistance of one (1) staff member, instead of two (2) as outlined in the resident's plan of care. The incident report further noted that the cause of the fall was determined to be the level of assistance provided to Resident #1 during the transfer.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1 on 08/13/15 at 10:30 AM confirmed she transferred Resident #1 without asking for assistance from another staff member, which resulted in a fall for the resident on 08/04/15. The SRNA stated she was aware Resident #1 required the assistance of two (2) staff members when he/she was transferred but stated, "I don't know why I didn't get help to transfer" Resident #1, "but I should have."</p>	F 323		

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F 323	Continued From page 4	F 323			
F 425 SS-E	<p>Interview with the Administrator on 08/12/15 at 4:15 PM confirmed all staff had been trained to provide facility residents with the level of assistance outlined in the resident's plan of care to prevent falls. She stated Resident #1 should have been transferred with the assistance of two (2) persons as required, when he/she experienced a fall on 08/04/15, when the resident was transferred with assistance of one (1) staff person.</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 425			

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F 425	<p>Continued From page 5</p> <p>Based on observation, interview, record review, review of the facility's investigation, and review of the facility policy, it was determined the facility failed to ensure an effective system was in place for receiving, dispensing, and administering controlled/narcotic medications to facility residents for one (1) of five (5) sampled residents (Resident #3). Review of the facility investigation and interview with staff revealed a pack of Resident #3's Hydrocodone 10/325 milligram (mg) tablets (narcotic pain medication) was missing from the facility's excess narcotics cabinet when narcotics counts were conducted on 07/21/15. Observations of narcotics counts conducted on 08/12/15, revealed when staff counted the narcotics in the medication carts, the resident's excess narcotics stored in the excess narcotics cabinet were not accounted for at that time to ensure they were available for resident use. Therefore, when the narcotics in the excess narcotics cabinet were counted, staff was unable to recall the amount of narcotics stored in the excess cabinet for each facility resident.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Protocol for Narcotic Storage Sheet for Shift Change," not dated, revealed staff was to count the number of narcotics packs, as well as the number of narcotics count sheets per cart and would document that information on the Narcotic sheets every shift. However, the policy did not direct staff to count narcotics available for each resident that were located in two places, the facility medication carts and the excess narcotics cabinet, to ensure all the residents' narcotics had been accounted for during each shift.</p>	F 425			

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F 425	<p>Continued From page 6</p> <p>Review of the facility investigation completed 07/28/15, revealed staff identified that pack #3 of Resident #3's Hydrocodone 10/325 (mg) tablets, along with the corresponding count sheet to account for the resident's medication, was missing. The investigation revealed even though there had been no discrepancies identified during narcotics counts conducted during each shift in the facility, staff was unable to recall the last time pack #3 of Resident #3's narcotic pain medication had been accounted for. The resident's medication or the corresponding count sheet was never located.</p> <p>Observation conducted of a narcotics count in the facility on 08/12/15 at 3:00 PM revealed Licensed Practical Nurse (LPN) #1 and Registered Nurse (RN) #1 counted the narcotics located in the secure unit medication cart. After completion of the narcotics count from the medication cart, LPN #1 and RN #1 counted the medications located in the excess narcotics cabinet to ensure resident medications were available.</p> <p>Interview with LPN #1 on 08/12/15 at 3:50 PM revealed she had never been trained to count all the controlled medications which should be available for resident use in the medication carts, and in the excess storage cabinet at the same time, to ensure all medications were accounted for when facility narcotics counts were conducted. According to the LPN, after counting all the controlled medications located in the medication cart, "there would be no way to really remember the number of packs each resident should have stored in the cabinet." She also acknowledged if a resident's pack of medication along with the corresponding count sheet were missing from the excess storage cabinet, "We probably wouldn't</p>	F 425		

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F 425	<p>Continued From page 7</p> <p>realize that during our shift counts. We have so many medications to count here."</p> <p>interview with Unit Manager #1 on 08/13/15 at 2:30 PM revealed she conducted narcotics count audits twice monthly in the facility to ensure the facility's controlled medications were counted appropriately. She stated she had not identified any concerns related to the controlled medications located in the medication carts and the medications stored in the excess cabinet not being counted at the same time to ensure all medications were present when medication counts were conducted. Unit Manager #1 stated, "There was no way the nurse could remember" what each resident should have stored in the excess cabinet if those medications were not accounted for when medication counts were conducted. Therefore, if medications along with the corresponding sheets were missing from the excess medication storage cabinet, the facility process of counting narcotic medication would not identify the problem when counts were conducted each shift.</p> <p>Interview with the Director of Nursing (DON) on 08/13/15 at 2:10 PM confirmed staff had not been directed to compare medications located in the medication carts with the medications stored in the excess cabinet at the same time that narcotics counts were conducted in the facility. The DON stated, "There's no way to remember what medications should be available in the excess storage cabinet for the residents, after completing the medication counts in the carts, because we have a lot of medications here to account for." She stated if a resident had medication which should be stored in the excess cabinet, and the medication pack along with the</p>	F 425			

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F 425	Continued From page 8 corresponding count sheet was missing. It "probably" would not be identified by the facility's current practice of counting narcotics.	F 425			