

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

FORM APPROVED
OMB NO. 0938-0391

RECEIVED
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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 11/07/2013
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NAME OF PROVIDER OR SUPPLIER
HAZARD HEALTH & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
390 PARK AVENUE HAZARD, KY 40302
Division of Health Care Enforcement Branch

(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 A standard health survey was conducted on 11/05-07/13. Deficient practice was identified with the highest scope and severity at "E" level.	F 000		
F 253 SS=E	483.16(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, interview, and facility policy review, it was determined the facility failed to provide maintenance and housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior. Observation during the environmental tour on 11/07/13 revealed a hole in the wall in one resident room; one wheelchair with worn and torn armrests; a brown stain on a water fountain; one torn chair seat; one rocking chair with a broken armrest; one resident room door with sharp, chipped wood exposed; one oxygen concentrator with dried tan liquid substance on top of the concentrator and the concentrator was in need of cleaning; seven resident rooms with chipped sink counters; the wood finish on a drawer in a chest in one resident room was observed to be chipped with sharp edges exposed; and the vinyl baseboard in one resident room was observed to be torn and the	F 253	(SEE ATTACHED)	12-18-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Charlotte C. Hayes RN, MSN

TITLE
Administrator

(X6) DATE
11/29/13

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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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE HAZARD, KY 41702
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F 253	<p>Continued From page 1</p> <p>bed was observed to have worn/torn tape on the bed rails.</p> <p>The findings include:</p> <p>A review of the facility policy titled, "Protocol for Maintenance Services," which contained no date, revealed any staff that identified an item in need of maintenance repair was required to complete a maintenance work order request and place the work order request at a designated location at each nursing station. The policy revealed if a piece of equipment was in need of maintenance repair, the equipment would be removed from the resident care area until the equipment was repaired or replaced.</p> <p>Observation during the environmental tour beginning on 11/07/13 at 3:50 PM, revealed:</p> <ul style="list-style-type: none"> -Resident room 403 was observed to have one bed and there was a hole in the wall above the head of the bed. -A wheelchair with worn/torn armrests was observed in resident room 102-B. -A water fountain located on the 100 Unit hallway was observed to have a brown stain around the drain and the metal around the drain was dull in appearance and observed to be in need of cleaning. -A chair beside the aquarium in the Locked Unit of the facility was observed to have a torn seat cover. -A rocking chair located in the hall between resident rooms 405 and 407 was observed to 	F 253		
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F 253	<p>Continued From page 2 have a broken armrest.</p> <p>-The edges to the entrance door to resident room 214 were observed to be chipped and sharp edges were exposed.</p> <p>-An oxygen concentrator in resident room 215-B was observed to have a dried tan liquid substance on the top of the concentrator and was in need of cleaning.</p> <p>-A sink countertop with sharp, chipped edges was observed in seven resident rooms (resident rooms 209, 210, 211, 301, 302, 313, and 321).</p> <p>-The wood edges of a drawer in a chest in resident room 210 were observed to have chipped edges that were sharp.</p> <p>-The vinyl baseboard beside the hand sink in resident room 208 was observed to be torn.</p> <p>-Worn/torn tape was observed on the bed rails located in resident room 313-B.</p> <p>An interview conducted with the Acting Maintenance Supervisor on 11/07/13, at 4:20 PM, revealed he completed an environmental tour every week to identify maintenance concerns and also obtained work order requests from staff that are posted at the nursing stations; however, the Acting Maintenance Supervisor stated the items identified by the surveyor during the tour of the facility on 11/07/13 had not been identified prior to the survey.</p> <p>An interview conducted with the Housekeeping Supervisor on 11/07/13, at 4:25 PM, revealed she conducted a tour of the facility every day to</p>	F 253			

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F 253	Continued From page 3 identify any areas that were in need of housekeeping, and also completed a housekeeping tour of the facility once a week as part of the Quality Assurance process. In addition, the Housekeeping Supervisor stated staff was also required to notify the Housekeeping Department of any areas that need housekeeping services. However, the Housekeeping Supervisor stated she had not identified the housekeeping concerns identified by the surveyor during the tour conducted on 11/07/13.	F 253		
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 observation, interview, record review, and facility policy review, it was determined the facility failed to ensure services were provided in accordance with each resident's written plan of care for one of twenty-nine sampled residents (Resident #14). A review of the comprehensive	F 282	(SEE ATTACHED)	12-18-13

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F 282	Continued From page 4 plan of care for Resident #14 dated 08/28/12, revealed staff would provide urinary catheter care per the facility's protocol. A review of the facility's policy for providing catheter care revealed staff was required to coil and secure the catheter tubing after providing catheter care. Observation of catheter care on 11/06/13, at 4:15 PM for Resident #14 revealed after staff provided catheter care the catheter was left draped over the resident's leg to the bedside drainage bag and was not secured. The findings include: A review of the facility's policy for providing catheter care entitled, "Giving Catheter Care," undated, revealed staff was required to coil and secure the catheter tubing after providing catheter care. Review of the medical record for Resident #14 revealed the facility admitted the resident on 08/16/12, with diagnoses that included Quadriplegia, Infected Stage IV Pressure Sores, and Urinary Retention. Review of the most recent Minimum Data Set (MDS) quarterly assessment dated 09/18/13, revealed the resident had been assessed to have a Brief Interview for Mental Status (BIMS) of 15 and had no cognitive impairment. The facility had assessed the resident to require total support from staff for bed mobility, transfers, locomotion, dressing, eating, personal hygiene, bathing, and toilet use (which included managing a catheter). Review of the Comprehensive Plan of Care for Resident #14 dated 08/28/12, revealed staff was to provide urinary catheter care per the facility's	F 282			

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F 282	<p>Continued From page 5 protocol.</p> <p>Observation on 11/06/13, at 4:15 PM, revealed State Registered Nursing Assistant (SRNA) #15 provided urinary catheter care for Resident #14. At completion of the catheter care SRNA #15 was observed to position the catheter tubing over Resident #14's right leg and then to attach the bedside drainage bag on the side of the bed. The observation revealed SRNA #15 failed to coil and secure the urinary catheter tubing.</p> <p>Interview conducted with SRNA #15 on 11/06/13, at 4:25 PM, revealed she was responsible to review each resident's care plan at the beginning of every shift to determine if there had been any changes to the plan. The SRNA stated she was aware she should have coiled the catheter tubing and secured the tubing with a catheter securing Velcro strip attached to the resident's leg, and did not know why she had not.</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #4 on 11/07/13, at 10:35 AM, revealed she was the Clinical Coordinator for the 100 Unit of the facility, and made rounds several times daily to ensure staff provided care according to each resident's comprehensive plan of care. The LPN acknowledged staff was required to review each resident's plan of care at the beginning of every shift, and stated she monitored catheter care at random times during the shift, and had not identified any concerns related to staff not providing resident care in accordance with the comprehensive plan of care. The LPN stated Resident #14's catheter tubing should have been coiled and secured to his/her leg with a Velcro strip designed to secure the catheter tubing, at all times, to the resident's leg.</p>	F 282		

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F 282	Continued From page 6 Interview conducted with the Director of Nursing (DON) on 11/07/13, at 4:15 PM, revealed staff was required to review the comprehensive plan of care at the beginning of every shift to ensure care was provided in accordance with the comprehensive plan of care. The DON stated she made rounds every day throughout the facility to ensure care was being provided as directed by the comprehensive plan of care. However, the DON had monitored to ensure urinary catheters had been secured and she had not identified any concerns regarding staff not performing urinary catheter care as directed by the plan of care.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure three of twenty-nine residents (Residents #11, #14, and #22) received appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. A review of	F 315	(SEE ATTACHED)	12-18-13

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F 315	<p>Continued From page 7</p> <p>the facility's policy for providing catheter care revealed staff was required to ensure the catheter tubing was coiled and secured to the resident's leg (to prevent trauma). The policy also revealed staff was required to clean the catheter tubing from the meatus in a downward motion approximately four inches. Further review of the policy revealed staff should remove soiled gloves and "decontaminate" their hands after catheter care had been provided. Observation of catheter care for Residents #14 and #11 revealed after staff provided catheter care the catheter tubing was left draped over the residents' legs to the bedside drainage bags and was not secured. In addition, while observing catheter care for Resident #11, staff was observed to clean the catheter tubing in an upward motion toward the meatus. Observations of catheter care for Resident #22 revealed after staff provided catheter care the State Registered Nursing Assistant (SRNA) failed to remove his/her soiled gloves. The SRNA was observed to touch Resident #22's clean incontinence brief and the resident's bed linen, and to reposition the resident while he/she continued to wear the soiled glove.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Giving Catheter Care," which was undated, revealed staff was required to hold the catheter tubing near the meatus and clean from the meatus down the catheter approximately four inches with a wet soapy washcloth. The policy revealed staff was then required to rinse the catheter, and coil and secure the catheter tubing. Further review of the policy revealed staff was required to remove soiled gloves and "decontaminate" their hands after catheter care had been provided.</p>	F 315		
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F 315	<p>Continued From page 8</p> <p>1. Review of the medical record revealed the facility admitted Resident #11 on 07/19/12 with diagnoses including Hypertension, Diabetic Neuropathy, Pathological Fracture secondary to Sarcoma, and a History of Breast Cancer with a right breast lumpectomy and mastectomy.</p> <p>A review of the comprehensive care plan for Resident #11 dated 01/15/13 revealed the resident required an indwelling catheter due to pain and impaired mobility related to right pelvic sarcoma which caused a pathological fracture of the right acetabulum.</p> <p>Observation of catheter care provided for Resident #11 on 11/05/13 at 4:30 PM, revealed State Registered Nursing Assistant (SRNA) #3 cleaned the resident's right labia with a disposable wipe and then cleaned the left labia with a clean disposable wipe. SRNA #3 was then observed to wipe the catheter tubing with a clean disposable wipe by starting approximately six inches down the tubing and wiping toward the urinary meatus.</p> <p>Interview with SRNA #3 on 11/07/13, at 3:35 PM, revealed the SRNA had been trained to clean the catheter tubing downward and away from the urinary meatus when she provided catheter care for a resident and acknowledged she failed to clean the catheter tubing appropriately.</p> <p>Interview conducted with Unit Supervisor #1 on 11/07/13, at 3:40 PM, revealed she was responsible to monitor direct care staff to ensure care was provided appropriately to the residents. Unit Supervisor #1 stated she observed catheter care "randomly" to ensure the care was provided</p>	F 315		

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F 315	<p>Continued From page 9</p> <p>in a manner to prevent urinary tract infections and no problems had been identified.</p> <p>2. A review of the medical record for Resident #14 revealed the facility admitted the resident on 08/15/12, with diagnoses that included Quadriplegia, Indwelling Urinary Catheter, and Infected Pressure Sores.</p> <p>A review of the physician's orders for Resident #14 dated 08/15/12 revealed an order for the resident to have an indwelling urinary catheter to bedside drainage because the resident was admitted by the facility with diagnoses of Stage IV Pressure Sores and Urinary Retention.</p> <p>A review of the Comprehensive Plan of Care for Resident #14 dated 08/28/12, revealed staff was to provide urinary catheter care per the facility's protocol.</p> <p>A review of the most recent Minimum Data Set (MDS) quarterly assessment dated 09/18/13, revealed staff assessed the resident to have no cognitive impairment and to have a Brief Interview for Mental Status (BIMS) score of 15. The facility assessed the resident to require total support from staff for bed mobility, transfers, locomotion, dressing, eating, personal hygiene, bathing, and toilet use (which included managing a catheter).</p> <p>A review of documentation dated 10/04/13 on a "Nurse's Admission Record and Initial Assessment," dated 10/04/13, at 6:30 PM, revealed the facility readmitted Resident #14 from the hospital with a diagnosis of Pneumonia.</p> <p>On 10/07/13, documentation in the nurse's notes</p>	F 315		

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F 315	<p>Continued From page 10</p> <p>revealed staff noted there was a "tear on Resident #14's penis."</p> <p>Physician's orders dated 10/07/13, at 10:30 AM, revealed staff was to cleanse the resident's meatus with normal saline and apply triple antibiotic ointment to the meatus every shift and as needed due to the tear. An interview conducted with Resident #14's physician on 11/07/13, at 1:35 PM, revealed the resident had sustained the tear to the penis while at the hospital and prior to the resident's readmission to the facility.</p> <p>Interview conducted with LPN #7 on 11/07/13, at 10:00 AM, revealed she had completed the admission assessment on 10/04/13, when the resident had returned to the facility from the hospital. The LPN stated the tear on Resident #14's penis was present when the resident returned to the facility on 10/04/13. The LPN stated she was aware she should have documented the tear on the resident's penis at the time of readmission and failed to obtain a physician's order for treatment of the wound. However, the LPN revealed she had failed to do so and was unsure why she had not.</p> <p>Observation on 11/06/13, at 4:15 PM, revealed SRNA #15 and Licensed Practical Nurse (LPN) #5 provided urinary catheter care for Resident #14. The SRNA positioned the catheter tubing over Resident #14's right leg and attached the bedside drainage bag on the side of the bed after they had provided the care. However, the SRNA failed to coil and secure the urinary catheter tubing to the resident's leg to prevent trauma. Continued observation revealed a tear on the end of the resident's penis that was approximately 0.8</p>	F 315			

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F 315	<p>Continued From page 11</p> <p>centimeter in length by 0.3 centimeter in width, and there was a small amount of red bloody drainage observed from the tear. Interview with LPN #5 on 11/06/13, at 4:15 PM, also revealed the resident had been readmitted to the facility on 10/04/13 with a tear to the penis. The LPN stated she had not conducted the assessment but it had been her understanding the tear had happened at the hospital. The LPN stated she should have ensured the urinary catheter was secure after the SRNA provided catheter care to Resident #14. The LPN was unsure why she had not.</p> <p>An interview conducted with SRNA #15 on 11/06/13, at 4:25 PM, revealed the facility had provided training related to catheter care. The SRNA stated she was aware she should have coiled the catheter tubing and secured the tubing with a catheter securing Velcro strip attached to the resident's leg, and did not know why she had not.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #4 on 11/07/13, at 10:35 AM, revealed she was the Clinical Coordinator for the 100 Unit of the facility and made rounds several times daily to ensure staff provided care to meet the residents' needs. LPN #4 stated she monitored catheter care, including positioning of indwelling urinary catheters, on a random basis and had not identified any concerns. The LPN stated Resident #14's catheter tubing should have been coiled and secured to the resident's leg with a catheter securing Velcro strip after the catheter care had been provided. In addition, LPN #4 also acknowledged LPN #7 should have documented Resident #14's tear to the penis on the (re)admission assessment as well as contacted the resident's physician for treatment</p>	F 315			

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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 11/07/2013
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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 330 PARK AVENUE 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 315	<p>Continued From page 12</p> <p>orders. The LPN stated she monitors charts randomly and had not identified any concerns related to the accuracy of assessments.</p> <p>An interview conducted with the Director of Nursing (DON) on 11/07/13, at 4:15 PM, revealed staff was required to ensure urinary catheter tubing was secured with a Velcro strip attached to the resident's leg. The DON stated she conducted "rounds" throughout the facility on a daily basis and had not identified any concerns with urinary catheter care and/or tubing placement. The DON also revealed staff was required to document any skin problems on the admission assessment when the resident returns from the hospital. The DON stated she had been aware of the tear to Resident #14's penis but had not reviewed the admission assessment to monitor for accuracy. The DON stated LPN #7 should have placed the assessment regarding the tear to the resident's penis on the admission assessment, and then should have obtained a physician's order for treatment for the tear. The DON stated chart audits were done at random and no concerns regarding accurate assessments had been identified.</p> <p>3. A review of the medical record for Resident #22 revealed the facility admitted the resident on 10/07/13, with diagnoses that included Multiple Decubitus, Dementia, and Prostate Cancer.</p> <p>A review of the physician's orders for Resident #22 dated 10/07/13, revealed an order for the resident to have an indwelling urinary catheter to bedside drainage related to the resident's multiple decubitus.</p> <p>A review of the most recent Minimum Data Set</p>	F 315		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE 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 315	<p>Continued From page 13</p> <p>(MDS) admission assessment dated 10/16/13 revealed staff assessed the resident to have cognitive impairment and was unable to conduct the Brief Interview for Mental Status (BIMS) assessment. The facility assessed the resident to require total support from staff for bed mobility, transfers, bathing, and toilet use (which included managing a catheter).</p> <p>A review of the Comprehensive Plan of Care for Resident #22 dated 10/18/13, revealed staff was to provide urinary catheter care in accordance with the facility's protocol.</p> <p>Observation of catheter care conducted for Resident #22 on 11/07/13 at 10:30 AM revealed SRNAs #1 and #2 provided catheter care to the resident. SRNA #1 was observed to wear gloves during the provision of the catheter care. However, at the completion of the catheter care, SRNA #1 failed to remove the soiled gloves and wash her hands when care was complete and touched Resident #22's clean incontinence brief and the resident's bed linen, and repositioned the resident with the soiled gloves.</p> <p>SRNA #1 acknowledged in interview conducted on 11/07/13 at 10:40 AM that she had failed to remove the soiled gloves and to wash her hands as required after catheter care had been provided to the resident. The SRNA stated she "forgot" to remove the soiled gloves.</p> <p>An interview conducted with LPN #4 on 11/07/13, at 11:10 AM, revealed she was the Clinical Coordinator for the 100 Unit of the facility, and monitored catheter care on a random basis, and had not identified concerns related to catheter care. The LPN stated SRNAs were required to</p>	F 315		
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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE HAZARD, KY 41702
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F 315	Continued From page 14 change their gloves and wash their hands after catheter care had been provided. The LPN further stated the SRNA should have changed her gloves and washed her hands, before touching the resident and/or the resident's bed linen. An interview with the Director of Nursing on 11/07/13 at 3:00 PM revealed SRNAs had been trained to change their gloves and to wash their hands after catheter care had been provided to avoid potential contamination of other items. The DON acknowledged the SRNA should have changed her gloves and washed her hands after catheter care was provided to Resident #22.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	(SEE ATTACHED)	12-18-13

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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)	(X6) COMPLETION DATE	
F 329	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure one of twenty-nine sampled residents (Resident #3) was free from unnecessary drugs. The facility failed to ensure there were adequate indications for the use of Risperdal (antipsychotic) for Resident #3. The findings include: A review of the facility's policy titled "Protocol for review and Reduction of Psychoactive Medications," with a revision date of July 2012, revealed the consultant pharmacist would review the resident's drug regimen on a monthly basis. The policy stated the pharmacist would evaluate the use of medications, including the need for possible reductions, and make recommendations to the physicians as indicated. Observation of Resident #3 on 11/05/13, at 4:10 PM, revealed the resident was walking back and forth aimlessly in the common area of the locked unit. A review of the medical record for Resident #3 revealed the facility admitted the resident on 08/27/12 with diagnoses that included Alzheimer's, Dementia, and Anxiety. A review of the most current Minimum Data Set (MDS) significant change in condition assessment dated 10/22/13 revealed the facility had assessed the	F 329			

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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE HAZARD, KY 41702		
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F 329	<p>Continued From page 16</p> <p>resident as being severely cognitively impaired. The MDS also revealed the resident had not exhibited any behavioral symptoms during the assessment period. A review of the physician's orders revealed a physician's order for Resident #3 to receive 0.5 milligram (mg) of Risperdal (antipsychotic) orally twice a day. A review of a "Note to Attending Physician/Prescriber" form dated 09/30/13, revealed the Registered Pharmacist (RPh) had documented a notification to Resident #3's physician of the Food and Drug Administration's (FDA) warning that, "elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analysis of trials of off label uses of these medications were of limited clinical value for elders with dementia." Documentation on the form revealed the RPh had requested the physician to add a diagnosis to support the use of Risperdal for Resident #3. A review of the form revealed the physician had placed a check mark in the space on the form to acknowledge agreement with the RPh's recommendation and had added a diagnosis of "Psychosis" for Resident #3.</p> <p>An interview conducted with the facility's Consultant RPh on 11/07/13, revealed he was aware the physician had failed to provide an appropriate diagnosis to support the use of the Risperdal for Resident #3 in response to the pharmacist's recommendation. The pharmacist stated even though there continued to be a lack of an appropriate diagnosis to support the use of the Risperdal for Resident #3, he had not contacted the physician again regarding the use of the antipsychotic medication for Resident #3.</p> <p>An interview conducted with the Director of</p>	F 329			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2013
NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE HAZARD, KY 41702	
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F 329	Continued From page 17 Nursing (DON) on 11/07/13, at 4:15 PM, revealed she was responsible for reviewing RPh recommendations. The DON stated she reviewed all RPh records after they came back from the physician and stated she had not contacted Resident #3's physician to discuss the RPh's recommendation.	F 329		
F 428 SS=D	489.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure drug irregularities identified during the monthly drug regimen review conducted by the licensed pharmacist were reported to the physician for one of twenty-nine sampled residents (Resident #17). The licensed pharmacist made a recommendation regarding a gradual dose reduction for an anti-anxiety medication for Resident #17 on 07/26/13; however, there was no evidence the facility had informed the physician of the recommendation. The findings include:	F 428	(SEE ATTACHED)	12-18-13

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F 428	<p>Continued From page 18</p> <p>A review of the Pharmacy Drug Regimen Review policy, no date given, revealed the consultant pharmacist would review the residents' drug regimen monthly and any irregularities would be reported to the physician and the Director of Nursing (DON). According to the policy, drug irregularities would be noted by pharmacy memo on the "drug Regimen Review-Irregularity" report and maintained in the "drug regimen" notebook at each nurses' station. The policy further noted the DON would deliver the pharmacy recommendations to the Unit Supervisor (US) for physician notification.</p> <p>Review of the medical record revealed the facility admitted Resident #17 on 12/05/12 with diagnoses that included Dementia, Alzheimer's Disease, Coronary Artery Disease, Diabetes Mellitus, and Anxiety. Review of the resident's physician orders for November 2013 revealed the physician had prescribed 0.5 milligram (mg) of Alprazolam (antianxiety) three times a day.</p> <p>A review of the pharmacist's monthly medication regimen review revealed the pharmacist addressed a gradual dose reduction of the Alprazolam for Resident #17 on 07/26/13; however, review of the medical record on 11/06/13 revealed there was no evidence the physician had received the recommendation the pharmacist had made on 07/26/13, a timeframe of 103 days.</p> <p>Interview conducted with the Registered Pharmacist (RPh) on 11/06/13, at 2:55 PM, revealed he conducted the medication review for Resident #17 on 07/26/13. The RPh stated recommendations were given to the DON after the medication reviews were completed and the</p>	F 428		
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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE HAZARD, KY 41702
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F 428	<p>Continued From page 19</p> <p>DON was to ensure the recommendations were sent to the resident's physician. The RPh stated if he did not see a response in the resident's medical record within two months, he would make another recommendation.</p> <p>Interview conducted with Unit Supervisor #1 on 11/06/13, at 3:30 PM, revealed the RPh provided his recommendations to the DON and the DON was to give the pharmacist's recommendations to the Unit Supervisor to send to the physician for review. Unit Supervisor #1 stated the facility had utilized this process to inform the physician of the pharmacist's recommendations for approximately one month. Unit Supervisor #1 stated previously the Medical Records staff took the pharmacy recommendations to the physician; however, physicians failed to return the recommendations to the facility in a timely manner and the facility changed their process. Unit Supervisor #1 stated she was not aware of the pharmacist's recommendation that had been conducted on 07/26/13 for Resident #17.</p> <p>Interview with the DON on 11/06/13, at 3:45 PM, revealed the Pharmacist was required to provide her with the Pharmacist's recommendation after he completed the monthly medication regimen review. The DON stated she gave a copy of the recommendation to the Unit Supervisor, kept a copy for herself, and the Medical Records staff would send the original copy of the recommendations to the physician. The DON stated the Unit Supervisor maintained a copy of the recommendation in a notebook at the nurses' station and removed the copy when the original recommendation was returned from the physician. The DON acknowledged physicians had not always signed and returned the</p>	F 428		
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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 380 PARK AVENUE HAZARD, KY 41702
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F 428	Continued From page 20 pharmacist's recommendations to the facility in a timely manner. The DON stated since the Unit Supervisor had been faxing the recommendations to the physicians, the response from the physicians has improved.	F 428		

Hazard Health and Rehabilitation Center, Inc.
Annual Survey November 5-7, 2013
Plan of Correction

F 253

1. The hole in the wall in Room 403 was patched November 7, 2013. The wheelchair arm has been replaced. The water fountain has been cleaned and a replacement drain ordered due to the dullness. The chair with the torn cover & the rocking chair was removed from service immediately. The door of Room 214 has been repaired. The dirty oxygen concentrator was cleaned immediately. The wooden edges of the sink front facings/countertops & the drawer have been repaired. The vinyl baseboard has been glued/replaced. The tape on the bed has been replaced & repaired.
2. All resident areas are safe, functional, and sanitary. Thorough environment rounds were conducted through the facility by the Administrator, Director of Nursing, Maintenance Supervisor, and the Housekeeping Supervisor. Special emphasis was placed on observing the areas of concern identified on the environmental tour. All identified concerns have been corrected.
3. An in-service was conducted on December 10, 2013 by the DON and/or Administrator with all staff including housekeeping and maintenance staff regarding the importance of maintaining a safe, functional, and sanitary environment. The in-service addressed reporting items in need of repair/replacement/cleaning utilizing the CQI Referral Form or Maintenance Repair Request Form. It also included the importance of taking items out of use until repairs/replacements/cleaning has been completed.
4. The CQI Committee designees will conduct thorough environmental walking rounds on a weekly basis for one month, then monthly for one quarter to observe for items in need of repair/replacement/cleaning. Any irregularities will be corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: December 18, 2013.

Hazard Health and Rehabilitation Center, Inc.
Annual Survey November 5-7, 2013
Plan of Correction

F 282

1. Resident # 14 is receiving foley catheter care as per facility policy, including cleaning, coiling and securing the catheter tubing. His foley catheter was immediately secured with a Cath Secure upon the observation on November 5, 2013.
2. All residents with foley catheters were reviewed and observed to assure catheter care was being provided as per the facility's policy including coiling and securing with tape or a Cath Secure. No irregularities were found.
3. An in-service was conducted immediately by all Nursing Supervisors prior to all nursing staff working to review the facility's policy on catheter care including and emphasizing coiling and securing appropriately. A follow-up in-service was conducted by the DON on December 10, 2013 with all nursing staff again emphasizing coiling and securing foley catheters after providing catheter care as per policy.
4. The CQI Committee designees will select two residents per observation with foley catheters to observe catheter care being provided along with the catheter tubing being coiled and secured as per the facility's policy. These observations will be done weekly for 8 weeks then monthly for one quarter. Any concerns will be corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: December 18, 2013.

Hazard Health and Rehabilitation Center, Inc.
Annual Survey November 5-7, 2013
Plan of Correction

F 315

1. Residents # 11, # 14 and # 22 are receiving foley catheter care as per facility policy, including cleaning in the downward direction from the meatus, coiling and securing the catheter tubing with tape or a Cath Secure. The staff are removing soiled gloves and decontaminating their hands after catheter care and before providing other care for that resident.
2. All residents with foley catheters were reviewed and observed by nursing supervisors to assure catheter care was being provided as per the facility's policy including cleaning from the meatus downward, coiling and securing with tape or a Cath Secure. These observations included assuring staff was removing dirt gloves and decontaminating their hands & applying clean gloves prior to doing other care. There were no other skin impairment around the meatus of any of the residents with catheters and no irregularities in care according to the facility policy were found.
3. An in-service was conducted immediately by all Nursing Supervisors with all nursing staff prior to staff working to review the facility's policy on catheter care including and emphasizing cleaning from the meatus downward, coiling and securing appropriately with tape or Cath Secure. The importance of properly documenting on admission all impaired skin issues was emphasized. A follow-up in-service was conducted by the DON with all nursing staff on December 10, 2013 again emphasizing cleaning from the meatus downward, coiling and securing foley catheters with tape or Cath Secures after providing catheter care as per policy. Included in this in-service was the importance of documenting correctly all skin impairment on admission and removing dirty gloves, decontaminating their hands and applying clean gloves prior to providing other care.
4. The CQI Committee designees will select two residents per observation with foley catheters to observe catheter care being provided along with the catheter tubing being coiled and secured as per the facility's policy. The designee will also assess if the weekly/admission skin assessment included all areas of impaired skin integrity. These observations will be done weekly for 8 weeks then monthly for one quarter. Any concerns will be corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: December 18, 2013.

Hazard Health and Rehabilitation Center, Inc.
Annual Survey November 5-7, 2013
Plan of Correction

F 329

1. Resident #3 has had a dose reduction of his antipsychotic (Risperdal) from 0.5 mg BID to 0.25 mg BID. Initially his attending MD had added the diagnosis of "Psychosis" when asked for an indication for the antipsychotic. The MD has now added the diagnosis of "Schizoaffective Disorder."
2. All residents receiving an antipsychotic medication was reviewed by the consulting pharmacist for an appropriate indication/diagnosis for the use of the antipsychotic along with periodic dose reductions. All residents getting antipsychotics had an appropriate indication/ diagnosis and periodic dose reductions as requested by the RPh monthly as he evaluates the use of medications, the need for possible reductions, and make recommendations to the physicians as indicated.
3. An in-service was conducted on December 10, 2013 by the Director of Nursing with all nurses (LPN's and RN's) regarding antipsychotics and appropriate diagnoses/ indications for their use along with the facility policy titled "Protocol for Review and Reduction of Psychoactive Medications." Also an in-service was conducted by the Chief Pharmacist on November 27, 2013 with the Consulting Pharmacist to review the facility the facility's policy titled "Protocol for Review and Reduction of Psychoactive Medications." The importance of following up with the attending MD for lack of indication/diagnosis was stressed.
4. The CQI Committee designees will review 5 charts per week for one month then monthly for one quarter for appropriate indications/diagnosis for antipsychotic/psychoactive drugs. Any irregularities will be addressed and corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: December 18, 2013.

Hazard Health and Rehabilitation Center, Inc.
Annual Survey November 5-7, 2013
Plan of Correction

F 428

1. The attending MD of Resident #17 has been contacted again regarding a dose reduction for his anti-anxiety medication. The MD does not agree he is a candidate for reduction at this time his past history of combativeness & will still have episodes of resisting care & becoming combative.
2. All residents getting anti-anxiety medications have been reviewed to assure their MD's have been quarterly and PRN asked to consider a dose reduction of their anti-anxiety medications. All residents getting anti-anxiety medications did have quarterly and PRN dose reductions addressed or the staff/ Registered Pharmacist notified the MD and asked for a reduction as per the Pharmacy Drug Regimen Review Policy.
3. An in-service was conducted on December 10, 2013 by the Director of Nursing with all nurses (LPN's & RN's) to review the facility's policy titled "Pharmacy Drug Regimen Review Policy." The quarterly and PRN periodic reduction of anti-anxiety medications was stressed. Also the Chief Pharmacist in-serviced the Consulting Pharmacist on November 27, 2013 on the policy titled "Pharmacy Drug Regimen Review Policy."
4. The CQI Committee designees will review 5 charts per week for one month then monthly for one quarter to assure dose reductions are addressed periodically. Any irregularities will be addressed and corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: December 18, 2013

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185134	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2013
NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE HAZARD, KY 40702 Division of Health Care Southern Enforcement Branch	
(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
K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1985 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type III (000) SMOKE COMPARTMENTS: 10 COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Two Type II diesel generators A life safety code survey was initiated and concluded on 11/05/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "D" level.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029	(SEE ATTACHED)	12-18-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Charlotte C. Hayes RN MSW

TITLE

Administrator

(X6) DATE

11/29/13

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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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185134	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/05/2013
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
K 029	<p>Continued From page 1</p> <p>fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain hazardous areas by NFPA standards. This deficient practice affected one of ten smoke compartments, staff, and approximately eight residents. The facility has the capacity for 200 beds with a census of 191 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 11/05/13 at 11:18 AM, with the Director of Maintenance (DOM), an approximate 3 x 5-inch hole was observed in the ceiling access panel located in the Mechanical Room in the 300 Wing of the facility. Holes, gaps, and other unsealed penetrations in hazardous areas are required to be properly sealed to help prevent the spread of fire/smoke to other areas of the facility in case of fire.</p> <p>An interview on 11/05/13 at 11:18 AM, with the DOM revealed he was aware of this requirement,</p>	K 029		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185134	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2013
NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & RENABILITATION 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
K 029	Continued From page 2 however, he was unaware of the hole in the access panel.	K 029		
K 045 SS=D	<p>The findings were revealed to the Administrator upon exit on 11/05/13.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain exterior exit lighting in accordance with NFPA standards. This deficient practice affected one of ten smoke compartments, staff, and approximately 18 residents. The facility has the capacity for 200 beds with a census of 191 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 11/05/13, at 11:30 AM, with the Director of Maintenance (DOM), an exterior light outside the 200 Wing exit door was observed not to have any bulbs. Exits are required to be illuminated to the public way. An interview with the DOM on 11/05/13, at 11:30 AM, revealed he was aware the exit needed lighting; however, he was not aware the bulbs were missing from the fixture.</p>	K 045	(SEE ATTACHED)	12-18-13

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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE HAZARD, KY 41702	
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K 045	Continued From page 3	K 045		
K 147 SS=D	<p>The findings were revealed to the Administrator upon exit on 11/05/13.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical power strips were being used in an approved manner. This deficient practice affected three of ten smoke compartments, staff, and approximately 66 residents. The facility has the capacity for 200 beds with a census of 191 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 11/05/13, at 12:05 PM with the Director of Maintenance (DOM), a suction pump was observed to be plugged into a multi-outlet adapter (power strip) in resident room 108. Generally, power strips with surge protection may be used for resident TVs, computers, radios etc., on an as needed basis but not to be used with medical equipment or high-draw appliances to help prevent against electrical shock and fire.</p> <p>During the survey resident rooms 112, 113, 116, and 118 were also observed to be using medical equipment with power strips.</p>	K 147	(SEE ATTACHED)	12-18-13

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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE HAZARD, KY 41702	
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K 147	Continued From page 4 An interview on 11/05/13 at 12:05 PM with the DOM revealed he was aware power strips could not be used with medical equipment; however, he was not aware that one was being used in the resident's room. The findings were revealed to the Administrator upon exit on 11/05/13. Reference: NFPA 99 (1999 Edition). 3-3.2.1.2 D 2. Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147		

Hazard Health and Rehabilitation Center, Inc.
Annual Survey November 5-7, 2013
Plan of Correction

K 029

1. The hole in the ceiling access panel in the Mechanical Room on the 300 Unit has been repaired/replaced.
2. All fire barriers/walls were inspected and no other holes/penetrations were noted.
3. An in-service was conducted on December 5, 2013 by the Administrator with all Maintenance employees. The in-service included a review of Life Safety from Fire Regulation regarding fire/smoke barriers and the importance of maintaining all fire walls/barriers. Also an inspection of all fire walls will be added to their weekly check list to be checked weekly and as needed following work completed by outside contractors.
4. The CQI Committee designees will visibly check all fire walls weekly for one month then monthly for any penetrations. All irregularities will be addressed/repared immediately and then reported to the CQI Committee for further follow-up and review.
5. Completion Date: December 18, 2013.

Hazard Health and Rehabilitation Center, Inc.
Annual Survey November 5-7, 2013
Plan of Correction

K 045

1. The light outside the 200 Unit exit door was replaced immediately.
2. All other exterior exit lights were inspected with no others missing or not illuminating a public area.
3. An in-service was held December 5, 2013 by the Administrator with all Maintenance employees. It was stressed that all exterior lights leading to a public area are to be illuminated. Also exterior lighting inspections will be added to their weekly check lists.
4. The CQI Committee designees will inspect all exterior lights for illumination weekly for one month then monthly for one quarter. All concerns will be corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: December 18, 2013.

Hazard Health and Rehabilitation Center, Inc.
Annual Survey November 5-7, 2013
Plan of Correction

K 147

1. The multi-outlet adapters in Rooms 106, 112, 113, 116, and 118 have been removed and all medical equipment is being plugged directly into electrical wall outlets.
2. All rooms were inspected and all medical equipment are now plugged directly into electrical wall outlets.
3. An in-service was conducted by the Administrator on December 5, 2013 with all Maintenance employees regarding not using multi-outlet adapters with medical equipment. Also an in-service was conducted by the DON on December 10, 2013 with all other staff regarding not using multi-outlet adapters with medical equipment.
4. The CQI Committee designees will monitor all resident rooms for the use of multi-outlet adapters weekly for one month and monthly for one quarter. Checking for all medical equipment to be plugged directly into wall outlets will be placed on Maintenance Weekly Rounds Sheet. All concerns will be immediately corrected and then reported to the CQI Committee for further follow-up and review.
5. Completion Date: December 18, 2013.