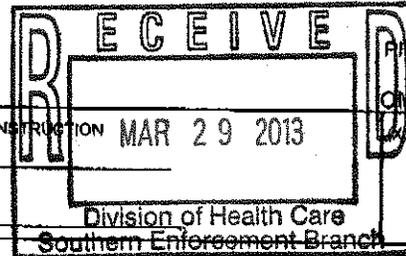


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 03/21/2013
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. WING _____	DATE SURVEY COMPLETED C 03/07/2013
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
F 000	INITIAL COMMENTS	F 000		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility polity, it was determined the facility failed to ensure the comprehensive care plan was reviewed and revised based on staff assessment</p>	F 280	(SEE ATTACHED)	4-12-13

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

Charlotte C Hayes RN, MSA

TITLE

Administrator

(X6) DATE

3/29/13

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.

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

PRINTED: 03/21/2013
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. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2013
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	
F 280	<p>Continued From page 1</p> <p>for one of three sampled residents (Resident #2). Review of Resident Incident Reports dated 02/26/13, 02/27/13, and 03/04/13 revealed the resident had sustained three falls and new interventions were to be put into place, however, review of the "at risk for falls" care plan revealed the care plan had not been revised to include the new interventions.</p> <p>The findings include:</p> <p>A review of the facility policy for "Resident Status Kardex," not dated, revealed the purpose was to ensure appropriate care was provided for residents residing in the nursing facility. The policy stated it was the responsibility of the licensed nurse to update the Kardex as changes occurred or place new problems on the Care Plan Update. In addition to a verbal report given by licensed nurses to State Registered Nurse Aides (SRNA), it was the responsibility of the SRNA to review the Kardex to ensure appropriate care was being delivered to the resident.</p> <p>A review of the facility policy, Falls Prevention Program, not dated, revealed the purpose of the policy was for all residents to be mobile safely. The policy further stated a goal of the program was to put in place interventions to limit or eliminate risk for residents that are a high fall risk.</p> <p>A review of the medical record for Resident #2 revealed the facility admitted the resident on 02/15/13 with diagnoses including Dementia and Hypertension. A review of the Minimum Data Set (MDS) admission assessment dated 02/21/13 revealed Resident #2 sustained a fall in the previous month before admission to the facility.</p>	F 280			

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

PRINTED: 03/21/2013
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. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2013
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	
F 280	<p>Continued From page 2</p> <p>Further review of the MDS revealed the resident required supervision with one person to assist with ambulation. A review of the comprehensive care plan dated 02/27/13 revealed the resident was at risk for falls because the resident was unstable when on his/her feet and the resident had a fall "in the last month." The care plan further revealed Resident #2 received antianxiety, antidepressant, and antipsychotic medications that could contribute to risk for falls.</p> <p>A review of the Resident Incident Report, dated 02/26/13, revealed Resident #2 sustained a fall while ambulating because his/her "feet became tangled up." Further review of the incident report revealed preventative measures to be taken to prevent further falls were to encourage Resident #2 to wear shoes when ambulating. A review of Resident #2's Kardex revealed no evidence the intervention was added to the Kardex. A review of the comprehensive care plan for "at risk for falls" and Care Plan Update revealed no evidence the care plan was updated to include the fall that occurred on 02/26/13 or with the new preventative intervention.</p> <p>A review of the Resident Incident Report dated 02/27/13, revealed Resident #2 sustained a fall while walking due to losing his/her balance. Further review of the incident report revealed preventative measures to be taken to prevent further falls were for one person to assist the resident when ambulating if the resident was weak or tired and to encourage the resident to wear shoes. A review of Resident #2's Resident Kardex revealed no evidence the new interventions had been added to the Kardex. A review of the comprehensive care plan for "at risk</p>	F 280			

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

PRINTED: 03/21/2013
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. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2013
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	
F 280	<p>Continued From page 3</p> <p>for falls" and Care Plan Update revealed no evidence the care plan had been updated with the fall or with the new preventative interventions.</p> <p>A review of the Resident Incident Report dated 03/04/13, revealed Resident #2 sustained a fall when the resident attempted to sit on the edge of the chair. The cushion moved and the resident fell. Prior to the fall, the resident was ambulating and carrying a personal blanket around his/her shoulders. Further review of the incident report revealed preventative measures to be taken to prevent falls were to redirect the resident to another chair when sitting, leave the resident's personal blanket in his/her room when ambulating, and to place two-sided tape to the cushion on the chair from which the fall occurred. A review of Resident #2's Kardex, comprehensive care plan, and Care Plan Update revealed the interventions were not added to Resident #2's care plan or care plan update.</p> <p>Interviews on 03/07/13 with SRNA #1 at 11:24 AM, with SRNA #2 at 11:56 AM, with SRNA #3 at 12:20 PM, and with SRNA #4 at 4:57 PM revealed Resident #2 required supervision with ambulation, which the SRNAs stated was "keeping an eye on" Resident #2 or "watching the resident close." The interview further revealed the SRNAs received a verbal report from the nurse at the beginning of the shift and were supposed to review the resident's Kardex to know what care each resident requires. The SRNAs were not aware of the interventions that were listed on the Resident Incident Reports for Resident #2.</p> <p>Interviews on 03/07/13 with LPN #1 at 12:45 PM</p>	F 280			

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

PRINTED: 03/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2013
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
F 280	<p>Continued From page 4</p> <p>and with LPN #2 at 1:05 PM revealed the nurse that was working when a fall occurred should investigate the fall and put new fall prevention interventions in place. The interview further revealed the Resident Kardex should be updated with the new interventions by the nurse, but the charge nurse should update the care plan.</p> <p>Interview on 03/07/13 at 4:31 PM with LPN #3 revealed the LPN was working when the fall on 02/27/13 occurred and the LPN felt like the intervention of providing Resident #2 with needed assistance with ambulation when weak or tired was appropriate and should have been added to the Kardex, but the LPN got busy and forgot to add the intervention. The interview further revealed it was the Charge Nurse's responsibility to add new interventions to the care plans.</p> <p>Interview on 03/07/13 at 5:19 PM with Registered Nurse (RN) #2 (Charge Nurse on Closed Unit) revealed it was his/her responsibility to sign off on incident reports and to ensure interventions added were appropriate. The RN further stated it was also his/her responsibility to update the care plans and to ensure the Kardex was updated with information from the incident reports. The interview further revealed the RN updated the care plans weekly and checked the Kardexes occasionally.</p> <p>Interviews on 03/07/13 at 7:30 PM with the Nurse Consultant, the DON, and the Administrator revealed the interventions that were put in place after each fall should have been added to the Kardex when the interventions were put in place. The interview further revealed the care plan should have also been updated with new</p>	F 280		

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

PRINTED: 03/21/2013
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. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2013
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	
F 280	Continued From page 5 Interventions by the charge nurse, but the charge nurse was new to the position and may not have been aware to update the care plan.	F 280			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure one of three sampled residents having pressure sores received necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing (Resident #1). A review of Resident #1's medical record revealed facility staff identified an area to the resident's right outer foot on 02/28/12 that was unstageable. However, further review of the medical record and interviews with facility staff revealed the facility failed to implement interventions to promote healing, prevent infection, and prevent new sores from developing. Further review of the medical record and interviews with facility staff revealed Resident #1 was transferred to the hospital on 03/08/12. A review of the hospital admission record revealed hospital staff assessed Resident #1 to have an unstageable	F 314	(SEE ATTACHED)	4-12-13	

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

PRINTED: 03/21/2013
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. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2013
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	
F 314	<p>Continued From page 6</p> <p>area to the right outer foot and had an unstageable area to the resident's left heel at the time of admission to the hospital.</p> <p>The findings include:</p> <p>A review of the facility's policy titled Skin Ulcers, not dated, revealed facility staff was to provide a systemic approach in the prevention and healing of skin ulcers. Further review of the policy revealed facility staff was to inspect potential sites of breakdown each nursing shift, and was to utilize pressure relief devices as indicated. The policy also revealed facility staff would conduct weekly skin integrity assessments on all facility residents.</p> <p>A review of Resident #1's medical record revealed the facility admitted the resident on 01/04/12, with diagnoses including Alzheimer's, Hypertension, and a history of Bladder Cancer. A review of a Significant Change Minimum Data Set (MDS) Assessment dated 02/20/12 revealed the resident required extensive assistance of two staff members with bed mobility, transferring, and bathing.</p> <p>A review of the weekly skin integrity assessments conducted on 02/28/12 (55 days after Resident #1's admission) and 03/02/12 (57 days after the resident's admission), revealed facility staff documented Resident #1 had an unstageable area to the right outer foot.</p> <p>A review of the resident's care plan updated 02/28/12 revealed staff was to monitor the discolored area to the outer aspect of the resident's right foot. Continued review of</p>	F 314			

195134

A. BUILDING _____

B. WING _____

C
03/07/2013

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HAZARD HEALTH & REHABILITATION CENTER

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 314	<p>Continued From page 7</p> <p>Resident #1's care plan revealed no further interventions were implemented to promote healing or to prevent new pressure sores from developing.</p> <p>Further review of the medical record revealed Resident #1 was transferred to the hospital on 03/08/12 at approximately 10:30 PM and was later admitted. A review of the hospital admission record revealed hospital staff conducted an initial skin assessment on 03/09/12 at 2:00 AM and also noted Resident #1 had an unstageable area to the outer aspect of the resident's right foot. However, documentation by the hospital staff on the day of the resident's admission revealed Resident #1 also had an unstageable area to the left heel.</p> <p>An interview with Unit Manager (UM) #1 on 03/07/13 at 5:00 PM revealed she had been responsible to review and develop a plan of care, including interventions to be implemented, for the unstageable area on the outer aspect of Resident #1's right foot that had been identified on 02/28/12. However, the UM stated monitoring the unstageable area to the resident's outer foot was the only intervention she had developed for staff to implement.</p> <p>An interview with the Director of Nursing (DON) on 03/07/13 at 7:30 PM revealed nursing staff was responsible to develop and implement interventions related to the prevention and/or treatment of pressure areas. According to the DON, staff should have implemented other interventions for Resident #1's unstageable area identified on the resident's right outer foot including "floating the resident's foot" on pillows to</p>	F 314		

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

PRINTED: 03/21/2013
FORM APPROVED
OMB NO. 0936-0391

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 03/07/2013
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	
F 314	Continued From page 8 relieve pressure to the heel area. The DON was not aware of Resident #1's unstageable area that had developed to the left heel prior to the resident's transfer to the hospital on 03/08/12.	F 314			
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 observation, interview, record review, and review of the facility policy it was determined the facility failed to ensure one of three residents received adequate supervision. Resident #2 sustained three falls at the facility from 02/26/13 to 03/04/13 (six days). The facility listed interventions on the incident report after each fall; however, the facility failed to include the interventions on Resident #2's Kardex and care plan (guides the staff uses to ensure appropriate care is being delivered). In addition, Resident #2 often refused to wear shoes and refused to allow staff to assist the resident with ambulation; however, the facility failed to revise interventions to prevent falls and continued to list wearing shoes and assisting the resident on Incident Reports as an intervention to prevent falls. The findings include:	F 323	(SEE ATTACHED)	4-12-13	

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

 PRINTED: 03/21/2013
 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. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2013
NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 399 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 323	<p>Continued From page 9</p> <p>A review of the facility policy entitled Falls Prevention Program, not dated, revealed the purpose of the policy was for all residents to be mobile safely. The policy further stated a goal of the program was to put in place interventions to limit or eliminate risk for residents that were a high fall risk. Further review of the policy revealed if a fall occurred, the incident should be evaluated to determine if areas of risk could be identified and interventions should be implemented that were based on the causative factor of the fall, eliminating or reducing the risk of injury related to the fall.</p> <p>A review of the medical record for Resident #2 revealed the facility admitted the resident on 02/15/13, with diagnoses including Dementia and Hypertension. A review of the Minimum Data Set (MDS) admission assessment dated 02/21/13 revealed Resident #2 sustained a fall in the previous month before admission to the facility. Further review of the MDS revealed the resident required supervision of one person to assist with ambulation. A review of the comprehensive care plan dated 02/27/13, revealed the resident was at risk for falls because the resident was unstable when on his/her feet and had a history of a fall "in the last month." The care plan further revealed Resident #2 received antianxiety, antidepressant, and antipsychotic medications that could contribute to risk for falls. Further review of the care plan revealed interventions in place to provide non-skid footwear when out of bed and to assist with ambulation to allow as much freedom as possible. A review of Resident #2's Kardex revealed the resident required supervision for ambulation.</p>	F 323			

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

PRINTED: 03/21/2013
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. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2013
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	
F 323	Continued From page 10 A review of the Resident Incident Report, dated 02/26/13, revealed the resident sustained a fall while ambulating because his/her "feet became tangled up," resulting in no injuries. Further review of the incident report revealed preventative measures to be taken to prevent further falls were to encourage Resident #2 to wear shoes when ambulating and continue with Physical Therapy/Occupational Therapy. A review of Resident #2's Resident Kardex revealed no evidence that encouraging the resident to wear shoes had been added to the Kardex. A review of the comprehensive care plan for "at risk for falls" and Care Plan Update revealed no evidence the care plan was updated to include the resident's fall and was not revised with the new preventative intervention that was listed on the Incident Report. A review of the Resident Incident Report, dated 02/27/13, revealed the resident sustained a fall while walking due to losing his/her balance resulting in a "scrape" to the outer orbit of the left eye. Further review of the incident report revealed preventative measures to be taken to prevent further falls were to provide the assistance of one staff person when the resident was ambulating if the resident was weak or tired and to encourage the resident to wear shoes when the resident permitted. A review of Resident #2's Resident Kardex, comprehensive care plan, and Care Plan Update revealed no evidence they were updated to include the need for one staff person to assist the resident with ambulating when the resident was tired or encouraging the resident to wear shoes.	F 323			

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

PRINTED: 03/21/2013
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. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2013
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	
F 323	<p>Continued From page 11</p> <p>A review of the Resident Incident Report, dated 03/04/13, revealed Resident #2 sustained a fall when the resident attempted to sit on the edge of a chair. The cushion moved and the resident fell. Prior to the fall, the resident was ambulating and carrying a personal blanket around his/her shoulders. The fall resulted in a hematoma to the left eye and a discoloration to the upper left arm and shoulder. The resident was sent to the Emergency Room for an evaluation. Further review of the incident report revealed preventative measures to be taken to prevent falls were to redirect the resident to another chair when sitting, leave the resident's personal blanket in his/her room when ambulating, and apply two-sided tape to the cushion on the chair. A review of Resident #2's Resident Kardex revealed these interventions were not added. A review of the comprehensive care plan and Care Plan Update for Resident #2 revealed no evidence the care plan had been updated with the fall or with the new preventative interventions.</p> <p>A review of radiology reports dated 03/04/13 revealed Computed Tomography (CT) scans of the spine, head, and face were normal.</p> <p>Observation of Resident #2 on 03/06/13 at 1:46 PM revealed the resident stood up from the couch and unsteadily ambulated approximately 25 feet unassisted and sat in a chair. Further observation on 03/07/13 revealed the resident stood up from the couch and unsteadily ambulated unassisted approximately 30 feet, stopped to talk to other residents, and sat in a chair at a table. Resident #2 then stood up unassisted and was assisted by staff to sit on the end of a chaise lounge chair.</p>	F 323			

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

PRINTED: 03/21/2013
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. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2013
NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 380 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 323	Continued From page 12 Interviews on 03/06/13 and 03/07/13 with SRNA #1 at 11:24 AM, with SRNA #2 at 11:56 AM, with SRNA #3 at 12:20 PM, and with SRNA #4 at 4:37 PM revealed Resident #2 required supervision with ambulation. The interview further revealed Resident #2 refused to wear shoes and at times would refuse assistance. The SRNAs denied being told in report or observing the Kardex being updated with any new interventions after the resident's falls. Interviews on 03/07/13 with LPN #1 at 12:45 PM and with LPN #2 at 1:05 PM revealed the nurse that was working when a fall occurred should investigate the cause of the fall and implement interventions based on the cause of the fall in an attempt to prevent another fall of that nature from occurring. The interview further revealed Resident #2 would at times refuse assistance and refused to wear shoes, but to their knowledge no other interventions had been attempted. The interview further revealed the Resident Kardex should be updated with new interventions after each fall. The LPNs stated Resident #2 was appropriate to ambulate on his/her own most of the time, but required physical assistance at times. The interview further revealed if fall interventions were not successful new interventions should be implemented. Interview on 03/07/13 at 4:31 PM with LPN #3 revealed the LPN was working when Resident #2 fell on 02/27/13. LPN #3 stated she felt assisting Resident #2 with ambulation when the resident was tired/weak was an appropriate intervention after the resident fell. LPN #3 stated the intervention should have been added to the	F 323			

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

PRINTED: 03/21/2013
FORM APPROVED
OMB NO. 0938-0391

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 03/07/2013
--	---	--	---

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
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 13</p> <p>Kardex, but the LPN got busy and forgot to add the intervention. The LPN further stated he/she felt the resident should wear shoes to prevent falls; however, the resident refused to wear shoes most of the time. The interview further revealed if the interventions were not effective new interventions should be tried.</p> <p>Interview on 03/07/13 at 5:19 PM with Registered Nurse (RN) #2 (Charge Nurse on Closed Unit) revealed resident falls interventions were reviewed in the morning meetings and signed off on if appropriate/further recommendations were made. The RN further stated it was her responsibility to update the care plans with new interventions and to ensure the Kardex was updated. The interview further revealed the RN updated the care plans weekly and checked the Kardexes occasionally.</p> <p>Interviews on 03/07/13 at 7:30 PM with the Nurse Consultant, the DON, and the Administrator revealed falls should be investigated by the floor nurse and new fall prevention interventions put in place immediately. The interview further revealed if an intervention was not successful or was refused by the resident, a new intervention should be implemented. The Administrative staff further revealed the new interventions should be updated on the Kardex by the floor nurse and on the care plan by the charge nurse.</p>	F 323		
F 463 SS-E	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p>	F 463	(SEE ATTACHED)	4-12-13

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

PRINTED: 03/21/2013
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. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2013
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	
F 463	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the nurses' station was equipped to receive resident calls through a communication system from resident rooms for three unsampled residents. Observations on 03/06/13 revealed unsampled Resident B pushed/activated his/her call light and no evidence was observed that the communication system was functional. Interview with Resident B revealed the resident had been unable to alert staff for the need of assistance "all morning." Interviews with unsampled Residents A and C revealed they had been unable to alert staff for the need of assistance "a few times" because the facility's call system was not working properly. Interviews with staff confirmed the facility's call system had not functioned properly at times.</p> <p>The findings include:</p> <p>Interview with the Maintenance Director on 03/07/13 at 6:45 PM revealed the facility did not have a policy related to the call light system. The Maintenance Director stated he checked call lights monthly to ensure they were working but had no documentation available for review. The Maintenance Director stated during the monthly checks he had identified resident call lights which did not work, and the call lights were repaired when identified to be non-functional.</p> <p>Observation on 03/06/13 at 11:35 AM revealed Resident B activated the call light and the light on</p>	F 463			

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

PRINTED: 03/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/07/2013
--	---	--	---

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
--------------------	--	---------------	---	----------------------

F 463	<p>Continued From page 15</p> <p>the outside of the door did not turn on or the call bell did not chime at the nurses' station.</p> <p>Interview on 03/06/13 at 11:41 AM with Resident B revealed the resident's call light had not worked all morning because he/she had pushed it several times and staff had not come to the resident's room. The interview further revealed the resident's call light does not work often.</p> <p>An interview with Housekeeper #1 on 03/06/13 at 12:00 PM revealed the facility's call system "sometimes doesn't work right." The Housekeeper stated when the cord connection had been "jerked on too hard" the call lights would not work properly.</p> <p>An interview with Certified Nurse Aide (CNA) #5 on 03/06/13 at 12:05 PM confirmed the call light system in resident rooms had not worked "sometimes" (unable to recall a timeframe). The CNA stated she was responsible to make sure call lights were within reach of the residents but was not responsible to ensure the system was working correctly.</p> <p>Interview with Resident A on 03/06/13 at 4:00 PM revealed his/her call light had not functioned "a few times," which left the resident unable to alert staff of needed assistance. The resident continued to state he/she recalled on one occasion, when the call system hadn't functioned, it took facility staff "almost all day to realize my light was torn up."</p> <p>Interview with Resident C at 4:10 PM on 03/06/13 revealed his/her call system had not functioned "a few times" and stated, "It's a scary feeling when</p>	F 463		
-------	---	-------	--	--

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

PRINTED: 03/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1B5134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/07/2013
--	---	--	---

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
F 463	<p>Continued From page 16 you are unable to reach somebody."</p> <p>An interview with the Director of Nursing on 03/07/13 at 7:30 PM revealed CNAs were responsible to ensure call lights were within reach and working at the beginning of their shifts. CNAs were to notify Maintenance when the call lights were not working properly.</p>	F 463		

**Hazard Health and Rehabilitation Center, INC.
Plan of Correction
Complaint Survey – 3/7/13**

F 280

1. The Care Plan and Kardex of Resident # 2 have been updated/revised to include the new interventions for each fall. These interventions are given to the SRNA's during their verbal report prior to each shift.
2. All residents' Kardexes and Care Plans were reviewed for inclusion of all individualized interventions for that resident. All Care Plans were developed within seven days of the Comprehensive assessment. They were developed by the appropriate members of the Interdisciplinary Team and with the resident and/or Responsible Party invited to participate if they desired. The Care Plans/Kardexes were reviewed and revised after each assessment and as needed.
3. An in-service was conducted on March 13, 2013 by the DON and the Administrator with all Nursing Supervisors regarding the timeliness of updating/revising the Kardexes/Care Plans. An additional in-service was conducted by the DON on March 21, 2013 with all other licensed nurses as to completion of incident reports and individualizing interventions that address the cause of the incident and then placing those interventions on the incident report and the Kardex immediately in order for all staff to know what that resident needs.
4. The CQI Committee Designees will select up to 4 residents per unit. These residents' Kardex and Care Plan will be reviewed for inclusion of all individualized interventions and observations made to ensure interventions are in place. These audits will be conducted on a weekly basis for one month then monthly for one quarter. Any identified concerns will be corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: April 12, 2013

Hazard Health and Rehabilitation Center, INC.
Plan of Correction
Complaint Survey – 3/7/13

F 314

DISCLAIMER: THE COMPLETION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION THAT THE FACILITY AGREES WITH THE DEFICIENCIES AS STATED IN THE 2567. THE FACILITY IS COMPLETING THE PLAN OF CORRECTION BECAUSE IT IS REQUIRED BY STATE AND FEDERAL LAW. THE FACILITY DISAGREES AND DISPUTES THE DEFICIENCIES STATED IN THE 2567.

1. Resident # 1 is no longer a resident here.
2. All residents have been assessed for being at risk for skin breakdown and interventions are in place to prevent worsening or new breakdown. All necessary interventions are documented on the Kardex, Care Plan and Nursing Flow Sheets.
3. An in-service was conducted by the DON on March 21, 2013 with all licensed nurses. The in-service included individualizing interventions for those residents at risk of developing pressure ulcers and the importance of documenting those interventions. Also the in-service reviewed importance receiving necessary treatments and services to promote healing, prevent infection and prevent new sores from developing.
4. The CQI Committee Designees will select 2 residents per unit that have or are at risk of developing pressure ulcers. These residents Kardex/Care Plan will be reviewed for interventions for the prevention of pressure ulcers or the development of new ulcers. They will also observe these residents to assure the interventions are being carried out. These audits/observations will be conducted weekly for one month then monthly for one quarter. Any identified concerns will be corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: April 12, 2013

Hazard Health and Rehabilitation Center, INC.
Plan of Correction
Complaint Survey – 3/7/13

F 323

1. The Kardex and Care Plan for Resident # 2 have been revised to include interventions to prevent her from falling again. These interventions include new interventions that Resident # 2 will allow. Her environment is as free as possible of fall hazards. There is a SRNA Monitor in the Common Area to supervise residents at risk for falling & assist as necessary. Resident # 2 has not had another fall/incident.
2. All residents' environment is as free of accident hazards as possible and are being supervised as much as possible. Each resident has an up-to-date Fall Risk Assessment and appropriate, individualized interventions in place if assessed to be at risk for falling. All interventions are on each resident's Kardex and Care Plan.
3. An in-service was conducted by the Administrator & the DON on March 21, 2013 with all nursing staff. This in-service included identifying those residents at risk for fall/accidents using the Fall Risk Assessment, individualizing the interventions and placing the interventions on the Kardex and Care Plan. The in-service will also stress the importance of monitoring the effectiveness and modifying the interventions when necessary.
4. The CQI Committee Designees will select 4 residents per unit. They will assure these residents have been assessed as to see if they are at risk for falls and if so if they have individualized interventions listed on their Kardex and Care Plans. They will also check to see if these interventions have been reviewed/revised as needed. They will observe to see that the interventions are being carried out. During these observations they will also observe for any environmental hazards, presence of assessed needed assistive devices and staff supervision to prevent accidents. The audits will be conducted on a weekly basis for one month then monthly for one quarter. Any identified concerns will be corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: April 12, 2013

Hazard Health and Rehabilitation Center, INC.
Plan of Correction
Complaint Survey – 3/7/13

F 463

1. Residents' A, B and C call lights were immediately checked with only one needing repaired. Maintenance immediately assessed and repaired the non-functional call light.
2. All residents call lights (in their rooms, bathrooms and showers) were assessed to be functioning properly both outside the doors and at the Nurses' station. No further issues have been identified.
3. An in-service was conducted by the ADON with all nursing staff on March 12, 2013. The in-service stressed the importance of assuring all resident call lights are functioning properly. The call light policy was reviewed. In order to assess this each resident's call light will be pulled at the beginning of each shift. The SRNA will step to the door to assure the light is on over the door as well as at the nurses' station. Any non-functioning call lights will be reported immediately to Maintenance staff and the resident will be provided with a cow bell to use until the call light is functioning properly.
4. The CQI Committee Designees will select six residents' call lights at random per unit. They will pull the light on & assure it is functioning properly both over the door and at the nurses' station. These audits will be conducted weekly for one month then monthly for one quarter. Any identified concerns will be corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: April 12, 2013