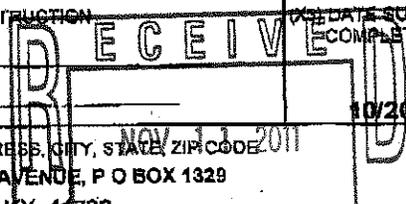


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/20/2011
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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE, P O BOX 1329 HAZARD, KY 4002
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 252 SS=D	<p>A standard health survey was conducted on 10/18-20/11. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a clean, comfortable, and homelike environment. During the environmental tour conducted on 10/20/11, a smoke odor was detected in the hallway leading to the designated resident smoking room which was caused from residents smoking in the smoking room. Observation of the smoking room revealed the exhaust air vents in the ceiling and the walls were dusty and dirty, and in need of cleaning. The walls were in need of painting.</p> <p>The findings include: The Maintenance Supervisor (MS) was asked for a policy related to maintenance repairs on 10/20/11, at 2:25 PM; however, a policy was not provided.</p> <p>Interviews conducted on 10/19/11, at 10:00 AM, with a group of residents revealed one</p>	F 252	(SEE ATTACHED)	11-30-11

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

TITLE
Administrator

DATE
11/11/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE, P O BOX 1329 HAZARD, KY 41702
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F 252	Continued From page 1 unsampled resident complained there had been an unpleasant smoke odor in the hallway leading to the smoke room, and the walls in the smoke room looked bad and were in need of cleaning. Observation during the environmental tour on 10/20/11, at 2:15 PM, revealed a strong smoke odor in the hallway leading to the designated resident's smoking room. Observation of the smoking room revealed the door leading to the hallway was closed. The air vents in the room were dirty with black soot on them and the walls had a tan stain, and were in need of cleaning. An interview conducted with the Housekeeping Supervisor (HS) on 10/20/11, at 2:20 PM, revealed she makes rounds every day and randomly checks all areas for housekeeping issues. The HS stated these issues had not been identified. An interview with the Maintenance Supervisor (MS) on 10/20/11, at 2:25 PM, revealed he was not aware of the smoke odor in the hallway leading to the smoking room. The MS stated the room was cleaned daily and as needed by the Housekeeping Department.	F 252		
F 253 SS=E	483.15(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	F 253	(SEE ATTACHED)	11-30-11

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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE, P O BOX 1329 HAZARD, KY 41702		
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F 253	<p>Continued From page 2</p> <p>by: Based on observation, interview, and record review, it was determined the facility failed to provide a sanitary, orderly, and comfortable interior. Three resident room doors and one women's shower room door with chipped wood, which created a surface difficult to cleanse and ensure a sanitary environment was maintained, one men's shower room with a tan stain in the tub which was unsanitary, and one men's shower with mold on the window which was unsanitary, were observed during the environmental tour on 10/20/11.</p> <p>The findings include:</p> <p>The Maintenance Supervisor (MS) was asked for a policy related to maintenance repairs on 10/20/11, at 2:25 PM; however, a policy was not provided.</p> <p>During the environmental tour of the facility on 10/20/11, at 2:15 PM, the following items were observed to be in need of cleansing and/or repair:</p> <ul style="list-style-type: none"> -The doors to resident rooms 200, 216, and 217, and the 200 Unit women's shower room were observed to have areas of chipped wood and created a surface difficult to cleanse and ensure a sanitary environment was maintained. -The bathtub in the 300 Unit men's shower room was observed to have a tan stain in the bottom of the tub. -A window in the 400 Unit men's shower room was observed to have mold on the glass on the window and in need of cleaning. 	F 253		

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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE, P O BOX 1329 HAZARD, KY 41702	
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F 253	Continued From page 3 An interview conducted with the Housekeeping Supervisor (HS) on 10/20/11, at 2:20 PM, revealed she makes rounds daily and randomly checks the facility for housekeeping issues. The HS stated these issues had not been identified. An interview conducted with the Maintenance Supervisor (MS) for the facility on 10/20/11, at 2:25 PM, revealed the facility utilized a work order system to request repairs. The MS stated any staff member could obtain a work order at the nurses' station to inform the Maintenance Department of anything that needed to be repaired. The MS stated he checked each nurses' station daily and made frequent rounds daily to monitor for work requests. The MS further revealed he made an environmental round to check for repairs needed daily and these issues had not been identified.	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 review of facility policy, it was determined the facility failed to ensure services were provided in accordance with each resident's Comprehensive Plan of Care for three of thirty-two sampled residents (Residents #2, #3, and #10). On 10/18/11, Resident #2 was observed to have a	F 282	(SEE ATTACHED) 11-30-11

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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE, P O BOX 1329 HAZARD, KY 41702
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F 282	<p>Continued From page 4</p> <p>Stage II pressure ulcer that was not covered by a dressing; on 10/19/11, staff failed to provide incontinence care to Resident #3 in a timely manner; and on 10/19/11, Resident #10 was not turned and repositioned in accordance with the resident's plan of care.</p> <p>The findings include:</p> <p>A review of the facility policy titled Resident Status Kardex (undated) revealed the licensed nurse was to give a verbal report to the State Registered Nurse Aide (SRNA) and to note the resident's care needs on a Kardex. According to the policy, it was the responsibility of the SRNA to review the Kardex to ensure appropriate care was delivered to the resident or to review the Kardex if the SRNA had questions regarding the delivery of resident care. An interview conducted with the facility Administrator on 10/20/11, at 4:30 PM, revealed the Kardex Policy was the most current policy regarding resident care plans.</p> <p>1. The facility admitted 91-year-old Resident #2 to the facility on 03/18/09, with diagnoses of Dementia, Cerebral Vascular Accident, and Insulin Dependent Diabetes Mellitus.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment for Resident #2 dated 10/11/11, revealed facility staff assessed Resident #2 to have a Stage II pressure ulcer to the right buttock. The care plan interventions developed by staff included to observe the resident's skin on a daily basis during activities of daily living, to clean the resident's pressure ulcer with normal saline, and to apply DuoDerm gel/dressing every three days, and as needed, to</p>	F 282		
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F 282	<p>Continued From page 5 the pressure sore.</p> <p>A skin assessment conducted by Licensed Practical Nurse (LPN) #8 on 10/18/11, at 4:10 PM, revealed Resident #2 had a Stage II pressure ulcer to the right buttock that was two centimeters by two centimeters (2 cm x 2 cm) in size. The wound was not covered by a dressing and there was no evidence of a dressing in the resident's incontinence brief or bedding. According to LPN #8, she had just started the shift and was not aware why Resident #2 did not have a dressing on the Stage II pressure ulcer.</p> <p>An interview conducted with State Registered Nurse Aide (SRNA) #1 on 10/19/11, at 12:33 PM, revealed the SRNA had provided care to Resident #2 during the first shift on 10/18/11, and was not aware that Resident #2's wound was not covered by a dressing. According to the SRNA, the aides receive a daily report and review the Kardex for knowledge of the resident's plan of care. Further interview with the SRNA revealed she had reviewed the Kardex for Resident #2 and had thought the area was healed. The SRNA had not noticed a dressing on Resident #2's buttocks and was not aware of the open area on the resident's buttocks.</p> <p>An interview conducted with LPN #2 on 10/19/11, at 1:00 PM, revealed the LPN had assessed the resident's wound at the beginning of the first shift on 10/18/11, and a DuoDerm dressing was clean, dry, and intact on Resident #2's Stage II pressure ulcer.</p> <p>An interview conducted with Registered Nurse (RN) #1, the Unit Manager of the 200 Hall,</p>	F 282		
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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE, P O BOX 1329 HAZARD, KY 41702
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F 282	<p>Continued From page 6</p> <p>revealed SRNAs were made aware of resident care needs in the daily report and were also required to review the resident's Kardex to ensure that care was provided in accordance with the resident's plan of care. Further interview revealed RN #1 made random rounds on the 200 Hall at least four times daily to observe resident care.</p> <p>2. A review of the medical record revealed the facility admitted Resident #3 on 02/12/10, with diagnoses to include Hypertension, Depression, Syncope, and Anxiety. A review of a quarterly Minimum Data Set (MDS) assessment dated 10/06/11, revealed Resident #3 was frequently incontinent of bladder, and required total care and the assistance of two persons with toileting. The MDS also revealed the resident had been assessed as at risk for the development of pressure ulcers.</p> <p>A review of the comprehensive care plan for Resident #3, dated 04/25/11, revealed facility staff would provide incontinence care to the resident as soon as possible after every incontinence episode.</p> <p>A review of the State Registered Nursing Assistant (SRNA) care plan (Kardex) revealed SRNAs were to assess the resident for incontinence episodes every two hours and were to change soiled briefs/pads as needed.</p> <p>Observation of Resident #3 on 10/19/11, at 12:10 PM, revealed the resident had been sitting in a wheelchair and had experienced an incontinence episode. SRNA #15 and the Unit Manager (UM) for the 300 Unit provided incontinence care to the</p>	F 282		
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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 990 PARK AVENUE, P O BOX 1329 HAZARD, KY 41702
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F 282	<p>Continued From page 7</p> <p>resident. However, as the resident was transferred from the wheelchair to the bed, the folded blanket that had been placed under the resident's buttocks in the wheelchair was observed to have a large yellow circle and appeared to have dried edges. The UM and the SRNA positioned the resident in the bed and proceeded to remove the resident's incontinence brief which was observed to be saturated with urine.</p> <p>An interview conducted with SRNA #15 on 10/19/11, at 12:20 PM, revealed the SRNA was aware she should check all incontinent residents for incontinence episodes every two hours and as needed. The SRNA stated she had been busy with another resident and had been late checking the resident. The SRNA stated she checks the Kardex to find information related to a resident's care needs. The SRNA also stated she was expected to check the Kardex daily and had checked at the beginning of her shift.</p> <p>An interview conducted with the UM for the 300 Unit of the facility on 10/19/11, at 12:25 PM, revealed SRNAs were expected to make rounds on incontinent residents every two hours and as needed. The UM also stated the SRNAs were expected to notify the nurse if they knew they were unable to get to the residents timely.</p> <p>An interview conducted with the Director of Nursing (DON) on 10/20/11, at 1:20 PM, revealed the SRNAs were expected to provide incontinence care every two hours and as needed. The DON stated the nurses were expected to make rounds to assess and ensure the residents were provided the care they</p>	F 282		
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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE, P O BOX 1328 HAZARD, KY 41702		
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F 282	<p>Continued From page 8 required. The DON also stated the UMs were also expected to make rounds to ensure residents were provided the care they required.</p> <p>3. A review of the medical record for Resident #10 revealed the facility admitted the resident to the facility on 07/22/09, with diagnoses that included Alzheimer's and functional incontinence. A review of the MDS assessment dated 09/18/11, revealed facility staff had assessed the resident as always incontinent of both bowel and bladder. The MDS also revealed the resident had been assessed to be at risk for the development of pressure ulcers.</p> <p>A review of the comprehensive care plan for Resident #10 dated 09/18/11, revealed facility staff was to turn and reposition the resident every two hours.</p> <p>A review of the Kardex for Resident #10 revealed facility staff would turn and reposition the resident every two hours from the side to the back, and then to the other side.</p> <p>Observation of Resident #10 on 10/19/11, at 9:35 AM, 10:00 AM, 10:30 AM, 11:05 AM, 11:20 AM, and 12:10 PM, revealed the resident was lying on his/her right side.</p> <p>An interview conducted on 10/19/11, at 1:15 PM, with Nursing Assistant (NA) #1 revealed she was required to look at the Kardex every shift to find the care required by the resident. In addition, the NA stated she was aware the resident was to be turned and repositioned every two hours; however, she had been busy with another resident.</p>	F 282			

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F 282	Continued From page 9 An interview conducted with the UM for the 300 Unit of the facility on 10/19/11, at 1:20 PM, revealed the resident should have been turned and repositioned every two hours. The UM further stated the NA was expected to check the Kardex daily to find the care needs required by the resident. An interview conducted with the DON on 10/20/11, at 1:20 PM, revealed the SRNAs were expected to check the Kardex daily to find the care needs required by the resident. The DON stated Resident #10 should have been turned and repositioned every two hours. The DON also stated the UMs were expected to make rounds several times every day to ensure care was provided in accordance with each resident's plan of care.	F 282		
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 observation, interview, record review, and a review of facility policy, it was determined the facility failed to ensure two of thirty-two	F 314	(SEE ATTACHED)	11-30-11

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F 314	<p>Continued From page 10</p> <p>sampled residents (Residents #2 and #10) received necessary treatment/services to promote healing or to prevent the development of new pressures sores. Resident #2 developed an unavoidable pressure area. However, staff failed to provide the necessary treatment/services to promote healing of the pressure area. In addition, Resident #10 was assessed to be at risk for the development of pressure sores and required assistance of staff for bed mobility. Staff failed to turn/reposition Resident #10 in accordance with the resident's comprehensive plan of care in an effort to prevent the development of pressure sores.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A review of the facility policy/procedure titled Skin Ulcers (undated) revealed that any skin irregularity identified by the State Registered Nurse Aide (SRNA) would be reported to the licensed nurse and documented in the nursing notes. An interview conducted with the Director of Nursing (DON) on 10/20/11, at 12:50 PM, revealed the policy was currently in use. <p>A review of the medical record for Resident #2 revealed the facility admitted the 91-year-old resident to the facility on 03/18/09, with diagnoses that included Insulin Dependent Diabetes Mellitus, Cerebral Vascular Accident, and Dementia.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment and comprehensive plan of care for Resident #2 dated 10/11/11, revealed the facility assessed Resident #2 to have a Stage II pressure ulcer to the right buttock. Interventions</p>	F 314		

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F 314	<p>Continued From page 11</p> <p>listed on the resident's care plan indicated staff was to observe the resident's skin daily, when they assisted the resident with activities of daily living. Staff was also to clean the resident's pressure ulcer with normal saline and apply a DuoDerm gel/dressing to the wound every three days and "as needed."</p> <p>A skin assessment conducted by Licensed Practical Nurse (LPN) #8 on 10/18/11, at 4:10 PM, revealed Resident #2 had a Stage II pressure ulcer to the right buttock. Further observation revealed the pressure ulcer was not covered by a dressing, as planned in the comprehensive plan of care. An interview conducted with LPN #8 at the time of the assessment revealed the LPN was not aware Resident #2 did not have a dressing on the Stage II pressure ulcer and did not know why the pressure ulcer was not covered.</p> <p>An interview conducted on 10/19/11, at 12:33 PM, with State Registered Nurse Aide (SRNA) #1 who had provided care for Resident #2 on the morning of 10/18/11, revealed the SRNA was not aware that Resident #2's wound was not covered by a dressing and that she had not reported any skin irregularities to the licensed nurse. According to SRNA #1, the aides received a daily report and reviewed the Kardex for knowledge of the resident's plan of care. Further interview with the SRNA revealed she was not aware Resident #2 had care plan interventions for a dressing on the buttocks and had thought the area was healed.</p> <p>An interview conducted with LPN #2 on 10/19/11, at 1:00 PM, revealed the LPN had assessed Resident #2's pressure area on 10/18/11, at the</p>	F 314		

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F 314	<p>Continued From page 12</p> <p>beginning of the first shift and at that time a DuoDerm dressing was clean, dry, and intact. Additional interview revealed the LPN had not been informed by the SRNA that Resident #2 did not have a dressing on the Stage II pressure ulcer or of any skin irregularities on 10/18/11.</p> <p>An interview conducted on 10/20/11, at 9:30 AM, with the 200 Unit Manager, Registered Nurse (RN) #1, revealed SRNAs were made aware of resident care needs during a daily verbal report that is conducted at the start of each shift. In addition, Unit Manager/RN #1 stated SRNAs were required to review the resident's Kardex to ensure that care was provided in accordance with the resident's plan of care. According to Unit Manager/RN #1, if a wound was not covered with a dressing the SRNA was required to report the irregularity to the licensed nurse.</p> <p>An interview conducted with the Director of Nursing (DON) on 10/20/11, at 12:50 PM, revealed SRNAs received a verbal report daily in addition to reviewing the Kardex to inform them of the care needs of the residents. Further interview with the DON revealed the SRNAs were required to report skin irregularities, to include when a dressing comes off a pressure ulcer or was missing, to the licensed nurse for evaluation and treatment. In addition a resident with a pressure ulcer was monitored daily by the licensed nurse to evaluate the condition of the pressure ulcer or dressing.</p> <p>2. A review of the facility's policy titled Skin Ulcers (undated) revealed nursing measures to prevent pressure sores would be followed for all residents and the staff would be expected to</p>	F 314		

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F 314	<p>Continued From page 13</p> <p>change the residents' positions at least every two hours.</p> <p>A review of the medical record for Resident #10 revealed the resident was admitted to the facility on 07/22/99, with diagnoses that included Alzheimer's and functional incontinence. A review of the MDS assessment dated 09/18/11, revealed staff had assessed the resident as incontinent of bowel and bladder. The MDS also revealed two staff persons were required to assist the resident with bed mobility and the resident had been assessed to be at risk for the development of pressure ulcers.</p> <p>A review of the comprehensive care plan for Resident #10 dated 09/18/11, revealed staff was to turn and reposition the resident every two hours to aid in the prevention of pressure sores.</p> <p>Observations of Resident #10 on 10/19/11, at 9:35 AM, 10:00 AM, 10:30 AM, 11:05 AM, 11:20 AM, and 12:10 PM, revealed the resident had been positioned to the right side during this timeframe of two hours and thirty-five minutes.</p> <p>Observation of a skin assessment conducted by the Unit Manager (UM) of the 300 Unit on 10/19/11, at 1:00 PM, revealed Resident #10 had three areas to the back of the resident's right upper leg that were reddened and blanchable. The incontinence pad under the resident was observed to be wrinkled in the areas where the resident's right leg had been positioned. The reddened areas were intact and there was no skin breakdown observed.</p> <p>An interview conducted with Nursing Assistant.</p>	F 314		
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F 314	Continued From page 14 (NA) #1 on the day of the observation, at 10/19/11, at 1:15 PM, revealed she was required to look at the Kardex every shift to find the care needs identified for each resident. In addition, the NA stated she was aware Resident #10's plan of care indicated the resident was to be turned and repositioned every two hours. However, according to NA #1, she had been busy with another resident and had not had time to get to the resident. An interview conducted with the UM for the 300 Unit of the facility on 10/19/11, at 1:20 PM, revealed the resident should have been turned and repositioned every two hours. The UM further stated the NA was expected to check the Kardex daily to find the care needs planned for the resident. An interview conducted with the DON on 10/20/11, at 1:20 PM, revealed aides were expected to check the Kardex daily to check the care planned for the resident. The DON also stated Resident #10 should have been turned and repositioned every two hours. The DON revealed the UMs were expected to ensure care was being provided by the SRNAs by making rounds on the residents.	F 314			
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	F 315	(SEE ATTACHED)	11-30-11	

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F 315	<p>Continued From page 15</p> <p>treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to ensure appropriate incontinence care was provided for one of thirty-two sampled residents. Resident #3 was observed to have soiled linen on the resident's wheelchair with a dried urine circle.</p> <p>The findings include:</p> <p>A review of the facility's policies titled Giving Female Perineal Care and Giving Male Perineal Care (no date) revealed there had not been a timeframe established for staff to monitor and/or change incontinence pads for residents.</p> <p>A review of the medical record for Resident #3 revealed the facility admitted the resident on 02/12/10, with diagnoses of Hypertension, Anxiety, Depression, and Syncope. A review of the Minimum Data Set (MDS) assessment dated 10/06/11, revealed Resident #3 was frequently incontinent of bladder and was not on a toileting program.</p> <p>A review of the comprehensive care plan for Resident #3 dated 04/25/11, revealed the resident would be cleaned as soon as possible after each incontinence episode. A review of the State Registered Nursing Assistant (SRNA) care plan revealed Resident #3 would be assessed for incontinence episodes and changed, with perineal</p>	F 315		

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F 315	<p>Continued From page 16 care provided, every two hours and as needed.</p> <p>Observation of Resident #3 on 10/19/11, at 12:10 PM, revealed the resident was sitting in a wheelchair and had experienced an incontinence episode. SRNA #15 and the Unit Manager (UM) were observed to provide incontinence care to Resident #3. As staff transferred the resident from the wheelchair to the bed, a folded blanket was observed to have been placed under the resident's buttocks in the chair. The folded blanket was observed to have a large yellow urine stain that appeared to have dried. In addition, the resident's incontinence brief was observed to be completely saturated with urine.</p> <p>An interview conducted with SRNA #15 on 10/19/11, at 12:20 PM, revealed she was aware she should have checked the resident for incontinence every two hours and as needed. The SRNA stated she had gotten busy providing care to another resident and had been late getting to the resident to check him/her for incontinence.</p> <p>An interview conducted with the UM for the 300 Unit of the facility on 10/19/11, revealed SRNAs were expected to make rounds every two hours if the resident had been assessed to be incontinent. The UM also stated if the SRNAs were not able to get to the incontinent residents timely they were expected to report to the nurse so other staff could provide incontinence care. The UM also revealed she felt Resident #3 had been wet for a "long" time.</p> <p>An interview conducted with the Director of Nursing (DON) on 10/20/11, at 1:20 PM, revealed</p>	F 315		
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F 315	Continued From page 17 SRNAs were expected to provide incontinence care every two hours and as needed. The DON stated the UMs were expected to monitor the care provided by the SRNAs to ensure care was provided to the residents.	F 315		
F 371 SS=E	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to prepare, distribute, and store food under sanitary conditions. Canned food items in the dry storage food supply area were observed to be dented and available for resident use. The findings include: According to interviews conducted on 10/20/11, at 12:30 PM, with the Dietitian, Dietary Manager (DM), and the Administrator, the facility did not have a written policy regarding food items stored in dented cans. According to the Dietitian and the DM it was a standard of practice at the facility to store dented cans in the DM's office to prevent the items from being used, and to be exchanged	F 371	(SEE ATTACHED)	11-30-11

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F 371	<p>Continued From page 18</p> <p>with non-dented canned food items from the food supplier.</p> <p>Observations of dry food storage areas conducted on 10/18/11, during the initial tour of the kitchen, revealed a fourteen-ounce can of spaghetti dinner, a fourteen-ounce can of spaghetti and meatballs, a three-pound can of berry topping, and a six-pound can of mandarin oranges with visible dents on the seams of the cans. The food items in the dented cans were stored on shelves with other canned food in the dry storage area and were available for use. Additional observation of the dry food storage area on 10/20/11, at 12:30 PM, revealed a #10 can of kidney beans, a #10 can of three-bean salad, and a #10 can of cranberry sauce with visible dents stored on shelves with other canned food items and were also available for resident use.</p> <p>An interview conducted with the DM on 10/20/11, at 12:30 PM, revealed the DM was not aware that food items in dented cans had been stored in the food storage area. According to the DM, the dented cans were missed when the stock items were placed on the shelves and should have been placed in the DM's office, away from the other canned food items, to prevent the use of the items.</p>	F 371		
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug</p>	F 431	(SEE ATTACHED)	11-30-11

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F 431	<p>Continued From page 19</p> <p>records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy it was determined the facility failed to label and store drugs and biologicals in accordance with currently acceptable professional principles. Observation of medication rooms revealed intravenous fluids, hand sanitizer, dispatch towels, and IV</p>	F 431		

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F 431	<p>Continued From page 20</p> <p>connection tubing had exceeded the manufacturer's recommended expiration dates and were available for resident use. In addition, two vials of flu vaccine were not labeled with the date they had been opened.</p> <p>The findings include:</p> <p>A review of the facility medication storage policy (not dated) revealed medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The policy also revealed outdated medications are immediately removed from stock and disposed of according to procedures for medication disposal.</p> <p>1. An observation on 10/20/11, at 3:15 PM, of the 100 Unit medication room revealed one Compliance Skin hand sanitizer, with a manufacturer's expiration date of March 2011; one container of Dispatch Hospital Cleaner disinfectant towels with bleach, with an expiration date of July 2011; one box of Dispatch Hospital Cleaner individually wrapped disinfectant towels with bleach, with an expiration date of June 2011; and two lengths of Medline nonconductive connecting tubing, with an expiration date of June 2011.</p> <p>An interview on 10/20/11, at 3:45 PM, with LPN #5 revealed staff had been instructed to check products for the manufacturer's expiration date prior to use.</p> <p>An interview on 10/20/11, at 4:00 PM, with the Unit Supervisor revealed staff on the night shift was responsible to stock medication rooms and</p>	F 431		

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F 431	<p>Continued From page 21</p> <p>to check for supplies that had exceeded the manufacturer's recommended expiration dates. In addition, according to the Unit Supervisor, staff should always check the expiration dates on a product before use.</p> <p>2. An observation on 10/20/11, at 2:25 PM, of the 300 Unit medication room revealed two bags of intravenous (IV) fluids that exceeded the manufacturer's recommended expiration dates. Based on observation, one 1,000-milliliter (ml) bag of 5% Dextrose had an expiration date of 11/01/10, and one 1,000-ml bag of 5% Dextrose had an expiration date of 02/01/11.</p> <p>An interview on 10/20/11, at 2:40 PM, with RN #2 revealed she was responsible to monitor the expiration dates on the stock medications/biological supplies in the 300 Unit medication room. The RN stated she checked the stock one time a week and had overlooked the two bags of IV fluids that had expired.</p> <p>3. Review of facility policy provided by the Administrator on 10/20/11, revealed multi-dose vials should be dated and initialed by staff when the vial was opened.</p> <p>Observation on 10/20/11, at 2:20 PM, of the 100 Hall medication room revealed two vials of Influenza Virus Vaccine (Fluvirin) had been opened and were stored in the refrigerator. Further observation revealed the two vials of Influenza Virus Vaccine had not been dated or initialed.</p> <p>Interview on 10/20/11, at 2:20 PM, with LPN #6 revealed all multi-dose vials were to be dated by</p>	F 431		
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F 431	Continued From page 22 the nurse who opened the vial. Interview on 10/20/11, at 2:45 PM, with the Unit Coordinator (UC) revealed it was the responsibility of the nurse who opened the vial to write on the vial the date when the vial was opened and to write the employee's initials on the vial of medication.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	(SEE ATTACHED)	11-30-11

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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE, P O BOX 1329 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 441	<p>Continued From page 23</p> <p>hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to provide a safe, sanitary environment to help prevent the development and transmission of disease and infections for three of thirty-two residents (Residents #30, #31, and #32). During observation of a medication pass, Licensed Practical Nurse (LPN) #5 failed to wash her hands or use hand sanitizer during the medication pass for Residents #30, #31, and #32 as required by the facility's infection control policy.</p> <p>The findings include:</p> <p>A review of the facility infection control policy revealed that standard precautions would be used in the care of all residents regardless of their diagnosis or presumed infection status. The policy review also facility staff was required to wash hands between resident contact.</p> <p>During observation of a medication pass on 10/18/11, at 4:15 PM, LPN #5 administered four medications to Resident #30 without washing/sanitizing her hands prior to or after</p>	F 441			

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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE, P O BOX 1329 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 441	<p>Continued From page 24</p> <p>administration of the medications. Observation of a medication pass on 10/18/11, at 4:20 PM, revealed LPN #5 crushed three medications, mixed the medications with yogurt, and fed the medications in the yogurt to Resident #31 without washing/sanitizing her hands prior to or after the administration of the medication. Observation of a medication pass on 10/09/11, at 4:30 PM, revealed LPN #5 administered two medications to Resident #32 without washing/sanitizing her hands prior to or after the administration of the medications.</p> <p>During an interview on 10/18/11, at 4:35 PM, LPN #5 stated she had been trained to wash her hands or use hand sanitizer between residents during medication administration. LPN #5 reported that her normal practice was to use hand sanitizer between resident contact unless her hands were soiled and then she washed her hands. However, the LPN reported she was nervous during the medication pass and could not recall sanitizing her hands between resident contact during the medication pass.</p> <p>During an interview on 10/18/11, at 5:15 PM, the Unit Supervisor stated all employees were trained to wash their hands or use hand sanitizer between resident contact. The Unit Supervisor stated hand sanitizer was kept on medication carts and sinks were available for staff use in each resident room.</p>	F 441		

Hazard Health and Rehabilitation Center, Inc.
Annual Survey October 18-20, 2011
Plan of Correction

F252

1. The resident's smoking room has been painted. The exhaust air vents in the ceiling and walls of the smoke room have been cleaned. An additional 1200 CFM exhaust fan has been added to assist in controlling the smoke odor in the hallway.
2. The resident's smoking room and the hallway leading to the designated resident's smoking room are safe, functional, and sanitary. Environmental rounds have been conducted in the resident's smoking room and the hallway leading to this designated area by the corporate maintenance consultant, maintenance supervisor, and the housekeeping supervisor. All identified concerns have been corrected.
3. An in-service was conducted on November 14, 2011 by the DON and/or Administrator with all staff regarding the importance of maintaining a safe, clean, sanitary environment. The CQI Referral Form and Protocol was also reviewed to remind staff on how to timely report areas in need of cleaning/repair. Additional in-services were conducted with the housekeeping staff on November 14, 2011 by the housekeeping supervisor regarding maintaining a safe, clean, and sanitary environment and to observe daily for areas that need additional cleaning/repairs. Additional in-services were conducted with maintenance staff on November 10, 2011 by the corporate maintenance consultant regarding maintaining a safe, functional, and sanitary environment.
4. CQI Committee designees will conduct walking rounds on a weekly basis for one month then monthly for one quarter to observe for smoke odor in the hallway leading to the designated smoking room and to observe for walls/exhaust vents in need of painting/cleaning. Any irregularities will be corrected immediately and reported to the CQI committee for further follow up and review.
5. Completion Date: November 30, 2011.

Hazard Health and Rehabilitation Center, Inc.
Annual Survey October 18-20, 2011
Plan of Correction

F253

1. The three resident's room doors and the one women's shower room door have been sanded and varnished and no longer have any chipped areas. The tan stain on the tub in the men's shower room has been cleaned and removed. The window in the men's shower room has been replaced due to the mold being between the two panes of glass.
2. All resident areas are safe, functional, and sanitary. Thorough environmental rounds were conducted throughout the facility by the corporate maintenance consultant, maintenance supervisor, and the housekeeping supervisor and identified concerns have been corrected.
3. An in-service was conducted on November 14, 2011 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 Referred Form or Maintenance Repair Request Form. Additional in-services were conducted with the housekeeping staff on November 14, 2011 by the housekeeping supervisor regarding maintaining a safe, clean, and sanitary environment. Additional in-services were conducted with maintenance staff on November 30, 2011 by the corporate maintenance consultant regarding maintaining a safe, functional, and sanitary environment. This in-service also included a review of the Preventive Maintenance Log Sheet to ensure doors, windows, etc. are periodically checked for proper functioning, in safe working order, and pose no danger to residents and the importance of prompt response to repair requests.
4. CQI Committee designees will conduct thorough 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: November 30, 2011

Hazard Health & Rehabilitation Center, Inc.
Plan of Correction
Annual Survey October 18-20, 2011

F282

1. Resident #2 is receiving dressing changes as ordered by the physician in accordance with the written plan of care. Resident #3 is receiving incontinent care per staff in a timely manner in accordance with the written plan of care. Resident #10 is being turned and repositioned timely, utilizing prop pillows to maintain body alignment in accordance with the written plan of care.
2. All residents with dressings ordered were reviewed and re-assessed to determine that dressings were in place as ordered by the physician. All residents that are incontinent were reviewed and assessed to ensure that they are receiving incontinence care timely per their plan of care. Residents that require staff assistance with turning and repositioning were reviewed to ensure they were being turned timely and effectively utilizing prop pillows to maintain their positions if indicated per the plan of care. The written plan of care & Kardex of each resident has been reviewed to ensure accuracy and were revised when indicated. No other irregularities were found.
3. An in-service was conducted by the Administrator and Director of Nursing on November 14, 2011 with all nursing staff, including nurse aides and nurses, on following the plan of care/Kardex when providing care and notifying the nurse or Clinical Coordinator if care needs have changed. The staff were also educated regarding the importance of the timeliness of incontinence care and turning/repositioning. The in-service included information on maintaining an ordered dressing to an area and reporting to the nurse if the dressing is not in place.
4. CQI Committee designee will select 6 charts at random to review the care plan and Kardex with observations made to ensure that the incontinence care and turning/repositioning is being done timely and correctly. The random sample will also include residents that have an ordered dressing and observations will be made to ensure dressings are intact as ordered by the physician. These audits/observations will be conducted on a weekly basis for one month, then monthly for the next quarter. Any identified concerns will be corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: November 30, 2011

Hazard Health & Rehabilitation Center, Inc.
Plan of Correction
Annual Survey October 18-20, 2011

F314

1. Resident #2 is receiving dressing changes as ordered by the physician. Resident #10 is being turned and repositioned timely, utilizing prop pillows to maintain body alignment.
2. All residents with dressings ordered were reviewed and re-assessed to determine that dressings were in place as ordered by the physician. Residents that require staff assistance with turning and repositioning were reviewed to ensure they were being turned timely and effectively utilizing prop pillows to maintain their positions. No other irregularities were found.
3. An in-service was conducted by the Administrator and Director of Nursing on November 14, 2011 with all nursing staff, including nurse aides and nurses, on following physician's orders and observing resident's skin daily during activities of daily living and notifying the nurse or Clinical Coordinator if care needs have changed. The in-service included information on maintaining an ordered dressing to an area and reporting to the nurse if the dressing is not in place. The staff were also educated regarding the importance of the timeliness of incontinence care and turning/repositioning to maintain body alignment.
4. CQI Committee designees will select 2 residents per unit. These residents will be observed to ensure that they are being turned/repositioned timely and correctly. The random sample will also include residents that have an ordered dressing and observations will be made to ensure dressings are intact as ordered by the physician. These audits/observations will be conducted on a weekly basis for one month, then monthly for the next quarter. Any identified concern will be corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: November 30, 2011

Hazard Health & Rehabilitation Center, Inc.
Plan of Correction
Annual Survey October 18-20, 2011

F315

1. Resident #3 is receiving incontinent care per staff in a timely manner every two hours and as necessary.
2. All residents that are incontinent of bladder were reviewed and assessed to ensure that they are receiving incontinent care/toileting assistance timely. The written plan of care & Kardex of Resident #3 was reviewed to ensure indicated timeframes were being observed. No other irregularities were found.
3. An in-service was conducted by the Administrator and Director of Nursing on November 14, 2011 with all nursing staff, including nurse aides and nurses, on providing incontinent care/toileting assistance timely per the each resident's individualized plan of care. The staff were also educated regarding the importance of the timeliness of providing the appropriate incontinence care.
4. CQI Committee designee will select 6 residents at random to observe for timely incontinence care/toileting assistance as assessed per their care plan. Direct observations will be made to ensure that the incontinence care/toileting assistance is being done timely and correctly. These audits/observations will be conducted on a weekly basis for one month, then monthly for the next quarter. Any identified concern will be corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: November 30, 2011

Hazard Health and Rehabilitation Center, Inc.
Annual Survey October 18-20, 2011
Plan of Correction

F371

1. The dented cans of food were removed from the dry storage food supply area.
2. All cans of food in the dry storage food supply area were checked for dents. No other dented cans were found.
3. An in-service was conducted by the dietary manager on November 14, 2011 for all dietary employees regarding the standard practice to remove and store all dented cans in the dietary manager's office to prevent the items from being used and to be exchanged with non-dented canned food items from the food supplier.
4. The CQI Committee designee will examine all canned food items in the dry storage food supply area for dents weekly for one month then monthly for one quarter. All irregularities will be corrected immediately and reported to the CQI committee for further follow-up.
5. Completion Date: November 30, 2011.

Hazard Health and Rehabilitation Center, Inc.
Annual Survey October 18-20, 2011
Plan of Correction

F431

1. The intravenous fluids, hand sanitizer, Dispatch towelettes, and IV tubing were discarded. Also the two vials of flu vaccine were discarded and replaced.
2. The medication rooms and refrigerators along with the treatment rooms and totes were thoroughly checked for expired medications and/or supplies. None were found. All opened multi-dose vials were checked for dates opened and initials of nurse who opened the vial. No other concerns were identified.
3. An in-service was conducted on November 14, 2011 by DON with all nurses. The in-service included weekly checks of all supply areas on the nursing units for expired medications and supplies. The in-service also included the importance of dating and initialing multi-dose vials when opened and disposing of them after 28 days. They were reminded to check expiration dates prior to using.
4. CQI Committee designees will inspect all supply areas for expired medications and supplies weekly for one month then monthly for one quarter. During this inspection, all opened multi-dose vials will be checked for dates opened and initials. Any irregularities will be corrected immediately and forwarded to the QA committee for further follow-up and review.
5. Completion Date: November 30, 2011.

Hazard Health and Rehabilitation Center, Inc.
Annual Survey October 18-20, 2011
Plan of Correction

F441

1. Residents #30, #31, and #32 are receiving their medications by nurses utilizing appropriate hand washing techniques. The nurse was immediately re-educated on washing her hands between each resident contact. All nurses have been observed for appropriate hand washing during med pass procedures.
2. All residents are receiving their medications by nurses utilizing appropriate hand washing techniques and/or hand sanitizer. All medication carts have hand sanitizer on them and each resident's room has a sink available for washing hands between resident contact.
3. An in-service was held on November 14, 2011 by the DON with all nurses. The in-service included proper hand washing technique, proper use of hand sanitizer, and their use before and after each resident contact.
4. The QA Committee designee will conduct observations of nurses during medication passes. These observations will be conducted at random and will include three nurses per week for one month or until all nurses have been observed then every six months thereafter. Any irregularities will be corrected immediately and reported to the QA committee for further follow-up and review.
5. Completion Date: November 30, 2011.

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

PRINTED: 05/29/2012
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OMB NO. 0938-0391

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 10/19/2011
NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE, P O BOX 1329 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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type III (000)</p> <p>SMOKE COMPARTMENTS: Ten</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 10/19/11, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.