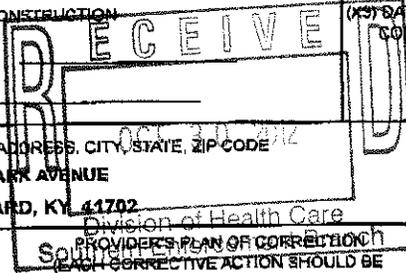


DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CENTERS FOR MEDICARE & MEDICAID SERVICES

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 09/27/2012
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 164 SS=D	<p>A standard health survey was conducted on 09/25-27/12. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 164 (SEE ATTACHED)		11-9-12



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlotte C. Hays, RN, MSW TITLE: Administrator (X6) DATE: 10/30/12

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

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F 164	<p>Continued From page 1</p> <p>Based on observation, interview, and review of facility policy, it was determined the facility failed to ensure personal privacy was provided when staff administered medication via a gastrostomy tube (G-tube) for one of thirty sampled residents (Resident #26). Observation on 09/25/12, at 4:35 PM, revealed Registered Nurse (RN) #1 failed to close the blinds to a window that faced the facility's rear parking area while administering the medications via G-tube.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Protocol for Maintaining Resident Privacy (not dated), revealed residents' personal privacy should be protected as much as possible during the provision of care. The policy directed staff to pull the privacy curtain and/or close the door to the resident's room when providing care, but failed to address that complete visual privacy should be maintained by closing the window curtains/blinds.</p> <p>Observation of medication pass for Resident #26 was conducted on 09/25/12, at 4:35 PM. RN #3 was observed to prepare four medications for administration via G-tube. RN #3 was observed to enter Resident #26's room and administer the G-tube medications to Resident #26. During the G-tube medication administration, RN #3 exposed Resident 26's abdominal area, but failed to ensure the window blinds were lowered to maintain complete privacy for Resident #26.</p> <p>Observation during the G-tube medication administration revealed the window blinds were raised, which fully exposed the lower half of the window. Further observation revealed the</p>	F 164		

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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE HAZARD, KY 41702
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F 164	<p>Continued From page 2</p> <p>window in Resident #26's room had a view of the facility's rear parking area.</p> <p>Interview on 09/25/12, at 4:45 PM, with RN #3 revealed she should have lowered the window blind and closed the blinds to ensure complete privacy before she exposed Resident #26's abdomen for the G-tube medication administration. RN #3 stated she was nervous and failed to close the window blinds.</p> <p>Interview on 09/27/12, at 3:15 PM, with the Director of Nursing (DON) revealed staff was required to provide privacy for residents by closing the door to the resident's room and pulling the privacy curtain around the resident's bed. The DON stated ensuring privacy by closing the window curtains/blinds had not been stressed but staff should close the window curtains/blinds when providing care to residents.</p>	F 164		
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</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 housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior. A Geri-chair on the 400 Unit had a torn area, a loose chair arm was observed in the 300 dining room, and torn/soiled duct tape was observed on the side rails in room 124B. In</p>	F 253	(SEE ATTACHED)	11-9-12

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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
F 253	<p>Continued From page 3</p> <p>addition, medication carts on the 200 Hall and 300 Hall were observed to be soiled with a sticky substance, and had medication debris in the bottom of the drawers.</p> <p>The findings include:</p> <p>1. A review of the facility policy titled Protocol for Maintenance Services (undated), revealed when an item was noted to be in need of repair/replacement a maintenance order request could be completed by any staff member and then given to the appropriate department. Further review of the policy revealed if a piece of equipment or item was in need of repair or broken, it was required to be removed from use/resident care area until repaired or replaced.</p> <p>Observations conducted during the initial tour on 09/25/12, at 12:45 PM, revealed a Geri-chair on the 400 Unit with a torn plastic side. Additional observations revealed torn and soiled duct tape on the bed rails in room 124 and a loose chair arm in the 300 Unit dining room. Additional observations conducted during an environmental tour with the Maintenance Director on 09/27/12, at 4:30 PM, revealed the above items had not been removed/repared and were still in use.</p> <p>An interview conducted with State Registered Nurse Aide (SRNA) #3 on 09/27/12, at 4:40 PM, revealed the SRNA was aware of the torn side on the Geri-chair and had not reported the item or filled out a maintenance request.</p> <p>An interview conducted with the Maintenance Director on 09/27/12, at 4:50 PM, revealed maintenance staff had checked all units on</p>	F 253		

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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE HAZARD, KY 41702
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F 253	<p>Continued From page 4</p> <p>09/26/12 and made repairs. However, according to the Maintenance Director, he had not identified the torn Geri-chair on the 400 Unit, the torn/soiled duct tape in resident room 124, or the loose chair arm in the 300 Unit dining room. Additional interview with the Maintenance Director revealed facility staff had not submitted maintenance requests to the Maintenance Department for the above items to be repaired.</p> <p>2. Observation of the 200 Unit B Hall medication cart on 09/27/12, at 3:45 PM, and the 300 Unit large medication cart on 09/27/12, at 4:10 PM, revealed the B Hall cart was soiled with a sticky substance and had medication debris in the bottom of the drawers. The large medication cart on the 300 Unit had a sticky substance with medication debris in the bottom of the medication drawers.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, LPN #3, Registered Nurse (RN) #2, and RN #5 on 09/27/12, at 4:35 PM, revealed the medication carts were required to be cleaned every week and as needed and the supervisors were to check for cleanliness weekly. The nurses stated there was a cleaning schedule and assignment for the nurses and CMAs to keep the medication carts clean and the nurses usually kept the carts clean as required. The Unit Supervisors (RN #2 and RN #5) stated they checked the medication carts for cleanliness every week, and did not know why the medication carts were dirty at the time of the observation on 09/27/12.</p>	F 253		
F 279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment</p>	F 279	(SEE ATTACHED)	11-9-12

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F 279	<p>Continued From page 5</p> <p>to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to develop a comprehensive plan of care for five of thirty sampled residents (Residents #18, 21, 22, 24, and 27). Residents #18, #21, #22, #24, and #27 were identified to have a history of positive tuberculin skin testing; however, the facility failed to develop a plan of care to ensure these residents were monitored for signs/symptoms of active tuberculin disease.</p> <p>The findings include:</p> <p>A review of the facility's Comprehensive Care Plan policy (no date) revealed a comprehensive</p>	F 279		

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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 380 PARK AVENUE HAZARD, KY 41702		
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F 279	Continued From page 6 care plan would be developed for each resident that included measurable objectives and timetable to meet a resident's medical, nursing, and mental/psychosocial needs identified in the comprehensive assessment. 1. Review of the medical record revealed the facility admitted Resident #18 on 05/25/01, with diagnoses to include Hypertension, Seizure Disorder, Hyperlipidemia, and Cerebral Vascular Accident. Further record review revealed the resident's chart was flagged "Positive PPD" (Purified Protein Derivative - a skin test for tuberculosis). A review of the comprehensive care plan implemented on 04/21/11 and reviewed on 07/25/12, for Resident #18 revealed there was no evidence the facility had developed a plan of care to address the resident's history of positive tuberculin skin testing (PPD) to include monitoring for the development of signs/symptoms of active tuberculosis. 2. Review of the medical record revealed the facility admitted Resident #27 on 05/15/95, with diagnoses to include Chronic Obstructive Pulmonary Disease, Chronic Anemia, Seizure Disorder, Depression, and Sleep Disorder. The resident's chart was observed to be marked "Positive PPD." Review of the comprehensive care plan implemented on 03/04/10 and updated on 06/26/12, revealed no evidence the facility had developed a plan of care to address the resident's history of positive tuberculin skin testing to include monitoring for signs/symptoms	F 279			

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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 09/27/2012
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)
F 279	<p>Continued From page 7 of active tuberculosis.</p> <p>Interview with RN #1 on 09/26/12, at 5:50 PM, revealed she was responsible for the development of resident care plans for the 200 and 300 Halls. RN #1 stated she had not developed a plan of care related to Resident #18's and Resident #27's history of positive PPD. The RN stated she was not aware this concern required the development of a care plan.</p> <p>3. Review of the medical record revealed the facility admitted Resident #22 on 06/26/12, with diagnoses to include Chronic Obstructive Pulmonary Disease, Depression, Diabetes, and Anxiety. The resident's chart was observed to be marked "Positive PPD."</p> <p>Review of the Comprehensive Care Plan dated 07/10/12, revealed Resident #22 had experienced a previous allergic reaction to PPD. Further review of the Comprehensive Care Plan related to Resident #22's allergies revealed staff was to contact the physician as needed, obtain an x-ray as ordered, and "flag" the chart to indicate the resident had an allergy to PPD. However, facility staff failed to ensure the care plan directed staff on what signs/symptoms (night sweats, cough, weight loss, fever, chills, and loss of appetite) to monitor that could indicate the resident had active pulmonary disease related to tuberculosis.</p> <p>Review of the record failed to reveal any documentation that staff had monitored Resident #22 for signs and symptoms of active disease.</p> <p>Interview conducted on 09/26/12, at 9:15 AM,</p>	F 279	

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F 279	<p>Continued From page 8</p> <p>with Resident #22 revealed he/she was a retired nurse and had been PPD positive for many years. Resident #22 stated to his/her knowledge staff had not monitored the resident for symptoms of active pulmonary disease.</p> <p>4. A review of the medical record for Resident #21 revealed the facility admitted the resident on 04/15/08, with diagnoses of Chronic Obstructive Pulmonary Disease and Shortness of Breath. Documentation revealed facility staff administered a PPD skin test to Resident #21 on 04/25/12, and the results of the test were determined to be positive on 04/26/12.</p> <p>A review of the care plan revision for Resident #21 dated 04/25/12, revealed an annual chest x-ray would be completed, however, there was no evidence staff developed interventions to monitor the resident for signs and symptoms of active tuberculosis.</p> <p>An interview conducted with RN #6 on 09/27/12, at 4:00 PM, revealed the RN had completed the care plan update for Resident #21 and had not considered any monitoring for Resident #21 other than an annual chest x-ray.</p> <p>5. A review of the medical record for Resident #24 revealed the facility admitted the resident on 05/24/12, with diagnoses including Congestive Obstructive Pulmonary Disease and according to the record the resident had a PPD positive history.</p> <p>A review of the plan of care developed for Resident #24 dated 06/06/12, revealed staff developed interventions related to the resident's</p>	F 279		

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F 279	Continued From page 9 past history of a positive PPD that included to contact the physician as needed, obtain a chest x-ray as ordered, report the results to the physician, and "flag" the chart to indicate the resident's positive PPD history. There was no evidence facility staff developed interventions for staff to monitor Resident #24 for signs and symptoms of active tuberculosis. An interview conducted with RN #6 on 09/27/12, at 4:00 PM, revealed the RN had developed the plan of care for Resident #24 and the interventions were the standard interventions printed by the computer system. The RN stated she had not considered the addition of any specific monitoring interventions related to tuberculosis on the care plan.	F 279		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure appropriate treatment and services, related to medication administration via gastrostomy tubes (G-tubes), were provided for one of thirty sampled residents (Resident #26).	F 322	(SEE ATTACHED)	11-9-12

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F 322	<p>Continued From page 10</p> <p>Registered Nurse (RN) #3 failed to verify placement of Resident #26's G-tube prior to administering medication to the resident. Additionally, RN #3 failed to flush Resident #26's G-tube with water, per facility policy, prior to and after the administration of medications.</p> <p>The findings include:</p> <p>A review of the Medication Administration Policy (not dated) revealed staff was to check G-tubes for placement and patency prior to the administration of medications. The policy failed to direct staff of the recommended procedure for checking for G-tube placement and patency. In addition, the policy directed staff to flush G-tubes with at least 30 milliliters of water before and after administering medications.</p> <p>Review of the medical record revealed the facility readmitted Resident #26 on 12/01/11, with diagnoses including Congestive Heart Failure, Status Post Acute Myocardial Infarction, Alzheimer's, and History of Lung Tumor.</p> <p>Review of the Significant Change in Condition assessment, with a reference date of 03/07/12, revealed Resident #26 was assessed to require G-tube feedings to ensure his/her nutritional needs were met. Further review revealed Resident #26 required total assistance of staff with all activities of daily living.</p> <p>Observation conducted during medication administration on 09/25/12, at 4:35 PM, revealed RN #3 prepared four medications and a protein liquid and administered the medications via Resident #26's G-tube. However, RN #3 failed to</p>	F 322	

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F 322	Continued From page 11 verify placement of the G-tube prior to administering the medications to Resident #26 and failed to provide a water flush prior to and after administering the medication. RN #3 was observed to insert air into the G-tube but failed to auscultate (listen) with a stethoscope. Interview with RN #3 on 09/25/12, at 4:45 PM, revealed she failed to verify correct placement of the G-tube prior to administering medications to Resident #26. The RN stated she was required to check G-tube placement by injecting air into the tube and listening with a stethoscope. RN #3 stated she had left her stethoscope on the medication cart in the hallway. The RN stated G-tubes should be flushed with at least 30 milliliters of water before and after medication administration. RN #3 stated she was nervous and failed to perform the procedure correctly. Interview with the Director of Nurses (DON) on 09/27/12, at 3:15 PM, revealed staff should verify G-tube placement prior to administering medications to residents by injecting air into the tube and listening with a stethoscope. Additionally, the DON stated G-tubes should be flushed with 30 milliliters of water before and after any medication administration.	F 322			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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 records are in order and that an account of all controlled drugs is maintained and periodically	F 431	(SEE ATTACHED)	11-9-12	

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

PRINTED: 10/26/2012
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 09/27/2012
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 431	<p>Continued From page 12 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, review of manufacturer's guidelines, Centers for Disease Control (CDC) recommendations, and review of facility policy/procedure, it was determined the facility failed to ensure multi-dose vial medications were labeled in accordance with currently accepted professional principles. A multi-dose vial of Tuberculin Purified Protein Derivative (PPD), Pneumococcal Vaccine, and</p>	F-431		

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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 09/27/2012
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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE HAZARD, KY 41702
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F 431	<p>Continued From page 13</p> <p>Novolin R insulin were available for use for residents but had not been dated when opened as required.</p> <p>The findings include:</p> <p>Review of the facility policy titled Medication Storage in the Facility, (not dated) revealed multi-dose vials were to be dated immediately with the date opened.</p> <p>Review of the manufacturer's guidelines on the label of the Tuberculin Purified Protein Derivative (PPD) revealed "once entered the vial should be discarded after 30 days."</p> <p>According to CDC recommendations posted on the CDC website, multi-dose opened or accessed vials should be dated and discarded in 28 days unless the manufacturer specified a different (shorter or longer) date for the opened vial.</p> <p>Observation of the medication refrigerator located in the 400 Hall medication room on 09/27/12, at 3:50 PM, revealed an open vial of PPD, Pneumococcal Vaccine, and a vial of Novolin R insulin. The vials were not dated to indicate when the vials had been opened for resident use.</p> <p>Interview on 09/27/12, at 4:00 PM, with Registered Nurse #4/the Unit Coordinator revealed staff was required to date and initial all multi-dose vials when they were opened to ensure they would be discarded on the expiration date.</p>	F 431		

Hazard Health and Rehabilitation Center, Inc.
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F 164

1. Privacy is being provided for Resident #26 during administration of her G-tube medications.
2. All residents are being provided privacy during care and administration of medications.
3. The DON/Administrator conducted an in-service on October 24, 2012 with all staff regarding privacy & ensuring that the privacy curtain is pulled, door closed, and curtains/ blinds are closed to ensure privacy during care.
4. The CQI Committee designee will observe staff providing different types of care to residents to ensure privacy is being provided at all times during care where exposure could be possible. The observations will be done weekly on all units for one month, then monthly for one quarter. Also during the supervisory staffs' every two hour round, they will observe staff providing care in such a way as to ensure privacy is maintained. Any irregularities will be corrected immediately and reported to the CQI Committee for further follow-up and review
5. Completion Date: November 9, 2012.

Hazard Health and Rehabilitation Center, Inc.
Annual Survey September 25-27, 2012
Plan of Correction

F 253

1. The Geri-chair's plastic side on the 400 Unit has been replaced. The loose dining chair arm in the 300 Unit dining room has been repaired/reinforced. The side rail on the bed in room 124 B has been repaired/replaced. The Medication carts on the 200 & 300 halls were thoroughly cleaned.
2. All resident areas are safe, functional, and sanitary. Thorough environment rounds were conducted through the facility by the Administrator, Director of Nursing, Maintenance Supervisor, and the Housekeeping Supervisor. All identified concerns have been corrected.
3. An in-service was conducted on October 24, 2012 by the DON and/or Administrator with all staff including housekeeping and maintenance staff regarding the importance of maintaining a safe, functional, and sanitary environment. The in-service addressed reporting items in need of repair/replacement/cleaning utilizing the CQI Referral Form or Maintenance Repair Request Form. It also included the importance of taking items out of use until repairs/replacements/cleaning were performed. An additional in-service will be conducted with all Nurses and Medication Aides on October 24, 2012 by the DON regarding wiping up all spills/sticky substances and medication debris immediately.
4. The CQI Committee designees will conduct thorough environmental walking rounds on a weekly basis for one month, then monthly for one quarter to observe for items in need of repair/replacement/cleaning. The Unit Supervisors will check all Medication Carts weekly for one quarter for cleanliness. Any irregularities will be corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: November 9, 2012

Hazard Health and Rehabilitation Center, Inc.
Annual Survey September 25-27, 2012
Plan of Correction

F 279

1. The Care Plans of Residents #18, #21, #22, #24, and #27 were updated to include monitoring for signs and symptoms of active tuberculin disease including night sweats, weight loss, cough, fever, chills, and loss of appetite.
2. All residents who have tested positive for TB have had their care plans reviewed and updated if indicated to ensure that all TB positive residents are being monitored for signs and symptoms of active tuberculin disease.
3. The DON/Administrator will conduct an in-service on October 24, 2012 with all MDS Coordinators and supervisory nurses regarding the importance of developing individualized care plans to meet the needs of each resident. The in-service will specifically address the care planning of observing signs and symptoms of active tuberculin disease.
4. CQI Committee designees will select at random 4 charts to review to ensure the care plan addresses all aspects of care including signs and symptoms of active tuberculin disease. These audits will be conducted on a weekly basis for one month then monthly for one quarter. Any irregularities will be reported to the CQI Committee for further follow-up and review.
5. Completion Date: November 9, 2012.

Hazard Health and Rehabilitation Center, Inc.
Annual Survey September 25-27, 2012
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F 322

1. Resident # 26 is receiving her G-tube medication correctly as per policy. Her tube placement is being verified per auscultation and her tube is being flushed with 30 cc of water both before and after medication administration.
2. All residents with G-tube were observed getting their medications correctly after verifying placement per auscultation and flushing with 30 cc of water before and after their medications are administered.
3. An in-service was conducted on October 24, 2012 by the DON with all nurses. This in-service stressed the importance of verifying G-tube placement per auscultation and flushing with 30 cc of water both before and after administering their medications.
4. CQI Committee designees will observe all nurses administering G-tube medications correctly. They will observe at least 4 nurses per week until all nurses have been observed giving G-tube medications. All observations will be completed on hire and twice a year FOR EACH NURSE DURING Medication Pass Audits.
5. Completion date: November 9, 2012.

Hazard Health and Rehabilitation Center, Inc.
Annual Survey September 25-27, 2012
Plan of Correction

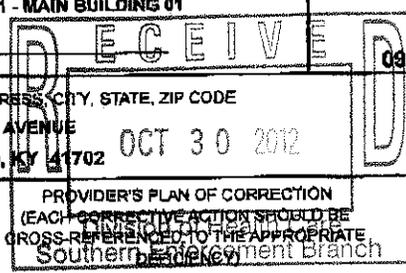
F 431

1. The opened & undated multi-dose vials of medications of 1 – PPD, 1 – Pneumococcal Vaccine and 1 – Novolin R Insulin were discarded and reordered at the facility's expense.
2. All Medication Rooms, refrigerators, and Medication Carts were thoroughly checked for opened multi-dose vials to ensure they were dated when opened, had the nurses' initial that opened the vial & were not outdated. All other drugs & biologicals were checked to ensure they had not expired. No other concerns were identified.
3. An in-service was conducted on October 24, 2012 by the DON with all nurses. The in-service included the Protocol for Storage of Drugs & Biologicals and the nurses were reminded of the importance of all drugs & biologicals being labeled appropriately when opened & the expiration dates being checked prior to using. All nurses have weekly cleaning assignments. They were reminded to check all drugs & biologicals to assure that they are labeled appropriately and have not expired while cleaning the Medication Carts, Medication Refrigerators, Treatment Closet/Totes, and Medication Rooms.
4. The CQI Committee designees will check the Medication Room, refrigerator, and the Medication carts for opened multi-dose vials to ensure they have been dated, initialed & are not expired. They will also be checking for proper labeling of drugs and biologicals and checking for expiration dates. The checks will be done weekly for one month then monthly for one quarter. The Consultant Pharmacist will conduct random Medication Room & Cart audits on a monthly basis and pm. Any irregularities will be corrected immediately and forwarded to the QA Committee for further follow-up and review.
5. Completion Date: November 9, 2012.

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: 186134	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2012
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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE HAZARD, KY 40302
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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) Southern Region	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1985 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type III (000) SMOKE COMPARTMENTS: 10 COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Two Type II diesel generators A life safety code survey was initiated and concluded on 09/26/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at	K 025	(SEE ATTACHED)	11-9-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlotte C. (Jays) P. MSA TITLE: Administrator (X6) DATE: 10/30/12

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

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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE HAZARD, KY 41702
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(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 025	<p>Continued From page 1</p> <p>least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain fire/smoke barrier walls in the attic area. This deficient practice affected three of ten smoke compartments, staff, and approximately forty-five residents. The facility has the capacity for 200 beds with a census of 193 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 09/26/12, at 1:30 PM, with the Director of Maintenance (DOM), an unsealed penetration of wiring was observed in the fire/smoke barrier wall in the 100 Wing attic area. Fire/smoke barrier walls must be properly maintained to prevent fire and smoke from spreading to other areas of the facility in a fire situation. The 200 and 300 Wing fire/smoke barrier walls were not reasonably accessible for inspection. Fire/smoke barrier walls must be reasonably accessible for inspection and maintenance purposes.</p>	K 025		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 380 PARK AVENUE HAZARD, KY 41702
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K 025	Continued From page 2 An interview with the DOM on 09/26/12, at 1:30 PM, revealed he checks behind contractors when they work in the attic; however, he must have missed the penetration of wiring. The DOM stated it is hard to maintain the attic area due to the limited access, and sections of the attic were not reasonably accessible for maintenance and inspection purposes.	K 025		
K 038 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exits were readily accessible to the public way. This deficient practice affected one of ten smoke compartments, staff, residents, and visitors. The facility has the capacity for 200 beds with a census of 193 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 09/26/12, at 10:25 AM, with the Director of Maintenance (DOM), an exit with delayed egress leading to an enclosed courtyard was observed not to be accessible to the public way. There was a magnetic locked gate with no posted combination</p>	K 038	(SEE ATTACHED)	11-9-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 038	<p>Continued From page 3</p> <p>to open the gate from the courtyard. Posted combinations are considered to be a key. An interview with the DOM on 09/26/12, at 10:25 AM, revealed the DOM was not aware this gate should be accessible.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.</p> <p>Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy. (d) A key is immediately available to any occupant inside the building when it is locked.</p> <p>Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which egress is to be made.</p> <p>19.2.2.2.4 Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path.</p>	K 038		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062	(SEE ATTACHED)	11-9-12

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K 062 SS=D	<p>Continued From page 4</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure that sprinkler heads were maintained as required. This deficient practice affected two of ten smoke compartments, staff, and approximately forty-five residents. The facility has the capacity for 200 beds with a census of 193 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 09/26/12, at 1:00 PM, with the Director of Maintenance (DOM), mismatched temperature rated sprinkler heads were observed in the Alzheimer's Unit and the 400 Unit of the facility. Sprinkler heads must be properly matched to ensure proper operation of the sprinkler system.</p> <p>An interview with the DOM on 09/26/12, at 1:00 PM, revealed some sprinkler heads had been replaced; however, replacement of the sprinkler heads ceased after a former Maintenance Supervisor was no longer at the facility.</p> <p>Reference: NFPA 13 (1999 Edition).</p> <p>5-3.1.5.2 When existing light hazard systems are</p>	K 062		
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K 082	Continued From page 5 converted to use quick-response or residential sprinklers, all sprinklers in a compartmented space shall be changed.	K 082		

Hazard Health and Rehabilitation Center, Inc.
Annual Survey September 25-27, 2012
Plan of Correction

K 025

1. The involved fire/smoke barrier walls & the unsealed penetration of wiring have been repaired/sealed. Access panels/doors have been ordered for installation
2. All barrier walls have been inspected for any other areas of concern. None were identified. With the installation of the access panels/doors, the fire/smoke barrier walls will be reasonably accessible for inspection and maintenance purposes.
3. An in-service will be conducted with the Maintenance Staff on October 24, 2012 by an outside contractor and the Administrator. The importance of maintaining the fire/smoke barrier walls & the accessibility of the walls for inspection & maintenance purposes will be stressed.
4. A Log Sheet for the preventive maintenance of the fire/smoke barrier walls will be placed in the Preventive Maintenance Log Book maintained by the Maintenance Director. The Maintenance Director or his designee will document their yearly inspection of all fire/smoke barrier walls & ease of access. They will also document their inspection after any outside contractor has had access to the attic area. The CQI Committee designee will review the Preventive Log Book on a yearly basis to ensure that this guidance is being followed. Any identified concerns will be corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: November 9, 2012.

**Hazard Health and Rehabilitation Center, Inc.
Annual Survey September 25-27, 2012
Plan of Correction**

K 038

1. The exit with the delayed egress leading to an enclosed courtyard is now accessible to the public way. The magnetic locked gate now has the combination posted to open the gate from the courtyard in case of any emergency. This courtyard is only accessible to residents by employees and at no time are residents allowed in this courtyard without a staff member being present to monitor them.
2. No other exits with the delayed egress leading to an enclosed courtyard exists.
3. An in-service will be conducted on October 24, 2012 by the DON/Administrator with all staff members explaining the courtyard gate combination lock & the posting of the code to operate the lock.
4. The CQI Committee designee will conduct weekly rounds to ensure that the combination remains posted. These rounds will be conducted at the same time all exit doors are checked for proper functioning. Any irregularities will be immediately corrected and reported to the CQI Committee for further follow-up and review.
5. Completion Date: November 9, 2012.

**Hazard Health and Rehabilitation Center, Inc.
Annual Survey September 25-27, 2012
Plan of Correction**

K 062

1. An outside contractor has been contracted to replace the mismatched temperature sprinkler heads. Each sprinkler head has to be measured and custom made for each point in the system. They will be installed as soon as available.
2. All other sprinkler heads within the facility were checked to assure they were the appropriate temperature rated. No others were found.
3. An in-service will be conducted on October 24, 2012 with the maintenance staff by the Administrator and an outside contractor as to the importance of making sure all sprinkler heads are properly matched as to temperature rating to ensure proper operation of the sprinkler system.
4. The Maintenance Department Head will monitor each sprinkler head immediately after any work is completed on the system to ensure that the system is operating correctly. A check will be completed weekly for one month, then monthly for one quarter and then immediately as necessary after any maintenance work is completed to the system.
5. Completion Date: November 9, 2012.