PRINTED: 01/20/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE C (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING Division of Health Care Southern Enforcement Branch B. WING 185134 12/21/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 390 PARK AVENUE HAZARD HEALTH AND REHABILITATION CENTER **HAZARD, KY 41702** PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 000 F 000 INITIAL COMMENTS A COVID-19 focused infection control survey was conducted on 12/21/2020. The facility was found to be out of compliance with 42 CFR 483.80 Infection Control. Deficient practice was identified with the highest scope and severity at E level. The total census was 151. 1/25/21 Infection Prevention & Control F 880 SS=E CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents. staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

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

possible communicable diseases or

(i) A system of surveillance designed to identify

TITLE

(X6) DATE

Electronically Signed

01/18/2021

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.

Facility ID: 100462

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F 880	Continued From pag		F 84	во				
**	persons in the facilit (ii) When and to who communicable disea reported; (iii) Standard and tra to be followed to pre (iv)When and how is resident; including b (A) The type and du depending upon the involved, and (B) A requirement th least restrictive poss circumstances. (v) The circumstance must prohibit emplor disease or infected a contact with resident contact will transmit (vi)The hand hygien by staff involved in or §483.80(a)(4) A sys identified under the corrective actions ta §483.80(e) Linens. Personnel must har transport linens so a infection. §483.80(f) Annual re The facility will cond IPCP and update the	om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a put not limited to: ration of the isolation, infectious agent or organism that the isolation should be the sible for the resident under the less under which the facility yees with a communicable skin lesions from direct the disease; and the procedures to be followed direct resident contact. Item for recording incidents facility's IPCP and the liken by the facility.						
	by:	TI IS NOT MET AS EMUELICED						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1''	PLE CONSTRUCTION G	, ,	DATE SURVEY COMPLETED
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F 880	Continued From pag	e 2	F8	80		
F 880	Based on interview, the facility's protocol determined the facility possible spread of C sampled residents (F and #6). Review of I and #6's Respiratory facility staff failed to assessments as required. The findings include: Review of the facility a revision date of 03 residents would be not COVID-19, to inclusion to the facility a revision date of 03 residents would be not COVID-19, to inclusion the facility a review revealed Centrel Prevention (CDC) gumonitoring, and treat would be followed. Review of the Respirate and the resident at least every document the reside saturation, assess resident assessments.	record review, and review of for COVID-19, it was by failed to prevent the OVID-19 for six (6) of six (6) Residents #1, #2, #3, #4, #5 Residents #1, #2, #3, #4, #5 Monitoring forms revealed complete COVID-19 uired by the facility's protocol. It is protocol "COVID-19," with /30/2020, revealed all nonitored daily for symptoms ude: oxygen saturation, lung ature. The protocol stated, if d and/or persist, the would be notified. Continued there for Disease Control and uidelines for identification, ting residents with COVID-19 Tratory Monitoring form required to assess the my twelve (12) hours and earl's temperature and oxygen espirations and lungs sounds,	F 8	1. Respiratory monitoring vicemperature, oxygen satural sounds and respirations is be and documented for resident #4 and # 5 at least every 12 no longer a resident at the first sheets were reviewed by the Coordinators and Infection Preventionist/Staff Developing Coordinator. Respiratory more being done with all residents documented at least every identified exceptions were a immediately. 3. In-services were conduct 12/22/2020 by the Director all the nurses, including Call Coordinators and Clinical Coregarding the importance of and documenting the monitories respiratory status includes: temperature, oxyglung sounds and respiration were re-inserviced to document the Respiratory Monitorie Nurse aide staff were also in	tion, lung being done bits #1, #2, #3, thours. #6 is acility. Ty Monitoring e Clinical ment conitoring is and is being 12 hours. Any addressed ted on of Nursing with re coordinators, f conducting oring of each which yen saturation, is. Nurses nent and initial ng Form. n-serviced by	
	Review of the Mand Roster dated 04/24/ Practical Nurse (LPI provided education	their initials in the appropriate assessment was completed. atory Meeting/In-service 2020, revealed Licensed N) #2, #3, and #5 had been regarding the Respiratory d completing the assessment ours.		the Staff Development Coor 12/22/2021 on signs/sympto COVID-19 and instructed to nurse immediately if a resid demonstrates any of the sy- complains during care. All were required to watch the "Closely Monitor Residents at https://www.youtube.com/w	oms of onotify the lent is noted to mptoms or facility staff training video for COVID-19"	=

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NAME OF PROVIDER OR SUPPLIER HAZARD HEALTH AND REHABILITATION CENTER			•	STREET ADDRESS, CITY, STATE, ZIP CODE 390 PARK AVENUE HAZARD, KY 41702				
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F 880	the facility admitted with diagnoses, who Obstructive Pulmor Type 2. Review of the Resp December 2020 for 12/01/2020, 12/02/2 12/05/2020, 12/07/2 and 12/15/2020, the evidence that staff saturation, temperal sounds on day shift staff no documente oxygen saturation, lung sounds were a 12/02/2020, 12/03/12/07/2020, 12/09/night shift. Review of Residenthe facility re-admit with diagnoses of 0 Hypertension and I Review of the Resp December 2020 for 12/07/2020, 12/08/12/12/2020, 12/13/12/19/2020 and 12 Resident #2's oxygrespirations, and Ic Continued review of Resident #2's oxygrespirations, and Ic Continued Resident #2	the resident on 03/13/2020, ich included Chronic hary and Diabetes Mellitus Diratory Monitoring form for Resident #1 revealed on 2020, 12/03/2020, 12/04/2020, 2020, 12/08/2020, 12/09/2020 Dere was no documented checked Resident #1's oxygen ature, respirations, and lung the Continued review revealed and evidence that Resident #1's temperature, respirations, and assessed on 12/01/2020, 2020, 12/04/2020, 12/05/2020, 2020 and 12/16/2020 during It #2's medical record revealed atted the resident on 12/09/2020 Chronic Kidney Disease, Diabetes Mellitus Type 2. Diratory Monitoring form for resident #2 revealed on 12/020, 12/16/2020, 12/11/2020, 12/20/2020 staff failed to assess gen saturation, temperature, and sounds on day shift. Tevealed staff failed to assess gen saturation, temperature, and sounds on 12/07/2020, 12/18/2020 and	F	880	Njv6xA. The training shall be complet by 1/18/2021 and is documented with in sheets and a staff roster checklist. attestation of the training from the Infection Preventionist is attached. At newly hired staff will be trained in orientation prior to working. Those employees on leave/quarantined will tin-serviced upon returning. 4. The Administrator and the Director Nursing reviewed https://www.cms.gov/Medicare/Provid nrollment-andCertification/QAPI/downs/Guidance for RCA.pdf regarding RC on January 15, 2021. The QAPI Committee, which includes Administrator, Director of Nursing, Infection Preventionist and a member the Governing Body met on 1/15/21 a performed a RCA regarding the deficiency. The RCA identified a neefurther training stressing the important of documentation of their respiratory monitoring. The Administrator reports the RCA finding to the Governing Bod 1/15/2021. QA Committee members, Infection Preventionist/Staff Developm Coordinator and Clinical Coordinators review the charts of 3 residents per u and make observations to ensure tha respiratory monitoring is being done a documented by nurses every 12 hour These audits will be done weekly for month then monthly for one quarter. irregularities will be reported to the Do and the QA Committee for further rev The Administrator updated the Gover Body on 1/18/21 regarding the correct Body on 1/18/21 regarding the correc	sign An I De Of er-E Iload A the Of nd d for ce ed by on nent will nit t and s. ON iew. ning		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
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F 880	the facility admitted to with diagnoses of De Pulmonary Disorder Review of the Respir December 2020 for for 12/05/2020 there was that staff assessed For saturation, temperate sounds on day shift, no evidence Resider temperature, respiral assessed on 12/10/2 Review of Resident to the facility admitted to with diagnoses of Marketum, Hypertension Review of the Respir December 2020 for 12/01/2020 and 12/0 Resident #1's oxyge respirations, and lund Continued review re Resident #4's oxyge respirations, and lund 12/02/2020, and 12/0 Review of Resident #4's oxyge respirations, and lund 12/02/2020, and 12/0 Review of Resident #4's oxyge respirations, and lund 12/02/2020, and 12/0 Review of Resident	#3's medical record revealed the resident on 04/17/2019 smentia, Chronic Obstructive and Anemia. #atory Monitoring form for Resident #3 revealed on a no documented evidence desident #3's oxygen ture, respirations, and lung Continued review revealed at #3's oxygen saturation, tions, and lung sounds were 1020 during night shift. #4's medical record revealed the resident on 12/19/2020 alignant Neoplasm of	F	880	action and directed plan of correction, Updates regarding audits will be provided by the Administrator to the Governing Body monthly for two month.	ded	
	Review of the care prevealed Resident #	cks Disease and Alzheimer's. plan dated 12/5/2020, 5 was positive for COVID-19. ratory Monitoring form for Resident #5, revealed on					

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F 880	12/07/2020, 12/08/20 12/18/2020, 12/19/20 was no evidence the #5's oxygen saturation revealed staff failed to oxygen saturation, te lung sounds on 12/03 12/05/2020, 12/06/20 12/17/2020, 12/18/20 12/20/2020 during ni Review of Resident if the facility admitted to with diagnoses of Ch Disorder and Hyperto Review of the Respin December 2020 for I 12/07/2020, staff fail oxygen saturation, te lung sounds on nigh Interview with LPN # revealed all resident signs and symptoms oxygen saturation, te lung sounds and the documented on the LPN #3 stated she ro Resident #5, includin have completed the LPN #3, there were and she might have box for 12/17/2020. Interview with LPN #	220, 12/05/2020, 12/06/2020, 2020, 12/09/2020, 12/17/2020, 2020 and 12/20/2020, there staff assessed Resident on, temperature, respirations, day shift. Continued review to assess Resident #1's emperature, respirations, and 3/2020, 12/04/2020, 2020, 12/10/2020, 12/15/2020, 2020, 12/19/2020 and ght shift. #6's medical record revealed the resident on 04/07/2020 aronic Obstructive Pulmonary ensive Heart Disease. Factory Monitoring form for Resident #6 revealed on ed to assess Resident #6's emperature, respirations, and t shift. #3, on 12/21/2020 at 4:15 PM, as were assessed daily for a for COVID-19 including emperature, respirations, and	F	380					

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F 880	Respiratory Monitoring residents were supported once per shift for sign COVID-19 including temperature, respiral the assessment was Respiratory Monitoring provided care for Respiratory Monitoring provided care for Respiratory Monitoring provided care for Respiratory with LPN with the LPN with the LPN with the LPN #2, on 12/21/20 on 12/21/2020 at 3:2 aware that they were residents' temperatures pirations, and lung shift and document to Respiratory Monitoring unable to explain whith the significant was residents of the LPN were residents.	tatus and completing the ag Form. She stated all used to be assessed at least as and symptoms of exygen saturation, ions, and lung sounds and documented on the ag form. LPN #4 stated she sident #2 routinely, including all have monitored the as unable to explain why the not completed. 1, on 12/21/2020 at 2:42 PM, 20 at 2:55 PM, and LPN #5, 2 PM revealed they were	F	880					
	12/21/2020 at 3:42 F had assessed reside of COVID-19 every approximately Octob required to document Respiratory Monitori Clinical Coordinator the forms every shift assessments were could be seen as the country of the DON reveals	er/November and were t the assessment on the ng form. She stated the was responsible for reviewing to ensure resident ompleted. Further interview ed she had not been notified arding staff assessing							

NAME OF PROVIDER OR SUPPLIER MAZARD HEALTH AND REHABILITATION CENTER 309 PARK AVENUE HAZARD, KY 41702 SUMMARY STATEMENT OF SEPTICENCIES HERRY TAG SUMMARY STATEMENT OF SEPTICENCIES HERRY TAG SUMMARY STATEMENT OF SEPTICENCIES HERRY TAG FRED HERRY TAG COntinued From page 7 Interview with Clinical Coordinator #1, on 12/21/20/200 at 4/07 PM, revealed staff were required to assess all residents every eight hours and document the assessment findings on the Respiratory Monitoring form. She stated she was aware that she was responsible for reviewing the form to ensure assessment and aleast daily monitoring of residents for signs and symptoms of COVID-19. She stated she was not aware that staff were required to conduct assessments and at least daily monitoring of residents for signs and symptoms of COVID-19. She stated she was not aware that staff were not documenting the assessments as required.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		1 ' '		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
HAZARD HEALTH AND REHABILITATION CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 7 Interview with Clinical Coordinator #1, on 12/21/2020 at 4:07 PM, revealed staff were required to assess all residents every eight hours and document the assessment findings on the Respiratory Monitoring form. She stated she was aware that she was responsible for reviewing the form to ensure assessments were completed; however, she had been filling in as a floor nurse and had not identified any concerns. Interview with the Administrator, on 12/21/2020 at 4:29 PM, revealed staff were required to conduct assessments and at least daily monitoring of residents for signs and symptoms of COVID-19. She stated she was not aware that staff were not			185134	B WING	B WING			12/21/2020	
F 880 Continued From page 7 Interview with Clinical Coordinator #1, on 12/21/2020 at 4:07 PM, revealed staff were required to ensure assessments were completed; however, she had been filling in as a floor nurse and had not identified any concerns. Interview with the Administrator, on 12/21/2020 at 4:29 PM, revealed staff were required with the Administrator of Conduct assessments and at least daily monitoring of residents for signs and symptoms of COVID-19. She stated she was not aware that staff were not					39	00 PARK AVENUE			
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	F 880	Interview with Clinical 12/21/2020 at 4:07 Pl required to assess all and document the as Respiratory Monitorin aware that she was reform to ensure asses however, she had be and had not identified Interview with the Add 4:29 PM, revealed strassessments and at residents for signs and She stated she was residents.	I Coordinator #1, on M, revealed staff were I residents every eight hours sessment findings on the ag form. She stated she was esponsible for reviewing the sments were completed; en filling in as a floor nurse if any concerns. ministrator, on 12/21/2020 at aff were required to conduct least daily monitoring of and symptoms of COVID-19. and aware that staff were not	F	880				