STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185134	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hazard Health and Rehabilitation Center	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and facility policy review, the facility failed to maintain and ensure recording of the reconciliation of controlled medication was occurring as required for 8 of 8 medication carts.The findings include: Review of the facility policy titled, Controlled Medication Storage effective date June 2024, revealed, at shift change, a physical inventory of all controlled medications was to be conducted by two licensed nurses or a licensed nurse and a medication aide. Further review revealed the inventory was to be documented on the (facility's) controlled medication accountability record. Review of the facility's, Routine Narcotic Count Record forms for January and February 2026 revealed numerous missing staff signatures across all eight medication carts indicating medication reconciliation had not consistently been documented as completed during shift change. Review of the forms revealed: the 100 Back Hall cart: had 24 missing signatures (Feb); the 100 Front Hall cart had five missing signatures for February: the 200 Front Hall cart had seven missing signatures for February and 16 missing signatures for January; and the 200 Back Hall cart had 18 missing signatures for February and 53 missing signatures for January. Continued review of the forms revealed: the 300 Back Hall two missing signatures for February, and seven missing signatures January; the 300 Front hall cart had 13 missing signatures for January; the 400 locked unit medication cart had 27 missing signatures for February and 39 missing signatures for January; and the 400 Hallway cart had 32 missing signatures for February, and 42 missing signatures for January. During interview on 02/25/2026 at 10:25 PM, Registered Nurse (RN) 11 stated on hand-off of the medication carts at shift change, two licensed staff were to reconcile the narcotics counts and both sign the counts to indicate they were correct. RN 11 stated the staff did perform the counts upon hand-off of the carts; however, were failing to sign off on the narcotics count sheet. The RN further stated it was important to sign the narcotic sheets to help protect themselves and the residents from misappropriation of narcotic medications. During interview on 02/25/2026 at 4:17 PM, the Director of Nursing (DON) stated two licensed nurses were to sign off on the narcotics sheet upon hand-off of the medication cart at shift change. She said, I have preached and preached to the staff to sign the narcotics count sheets as required. The DON stated not signing off on the narcotic count sheet at hand-off of the cart could cause significant issues if medications were missing. She further stated she had not provided education on the policy for medications and narcotic counts in at least six months or longer. Additionally, she stated the Clinical Coordinators should have been checking the signatures prior to turning the narcotic sheets in to medical records, and she had also failed to check the signatures herself in a while. During interview on 02/26/2026 at 11:50 AM, with RN 12, one of the Clinical Coordinators, stated she was supposed to be checking the narcotic count sheets to see if they had been signed off by two licensed staff as required. She further stated not signing the narcotic count sheets when handing off the cart could lead to issues if the counts were incorrect. During interview on 02/26/2026 at 4:15 PM, the Administrator stated her expectation was for two staff to count narcotics, and both sign the narcotic count sheet attesting that the counts were correct. She stated that was important in order to accurately track narcotics. The Administrator stated she should have been providing oversight to ensure the narcotic counts were being performed and documented as required.

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and review of the facility's policies, the facility failed to maintain an effective 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 for 5 of 41 sampled residents (Resident (R)4, R77, R28, R42 and R50).The findings include: Review of the facility's policy titled, Enhanced Barrier Precautions (EBP), dated 03/08/2024, revealed the EBP policy was implemented to reduce the transmission of multidrug-resistant organisms (MDROs) within the facility. Per review, the EBP were to be utilized in conjunction with standard precautions to provide targeted gown and glove use during high-contact resident care activities. Further review revealed high contact care activities included assisting with and providing hands on care. Review of the facility's policy titled, Infection Control dated 03/10/2024, revealed all nebulizer tubing was to be in a sealed bag when not in use. Further review revealed it was okay to take the tubing out of the bag to be used; however, it should be in a bag when not in use. 1. Observation on 02/23/2026 at 3:12 PM, revealed Certified Nursing Assistant (CNA) 2 failed to don (put on) Personal Protective Equipment (PPE) prior to providing care for R77 who was on Enhanced Barrier Precautions (EBP). Additionally, observation revealed CNA 2 failed to wash or sanitize her hands upon exiting R77's room after providing care. Observation on 02/23/2026 at 3:42 PM, revealed a sign on the door to R77'a room that stated, enhanced barrier precautions. Further observation revealed there was a gown and gloves located on the inside of the door. During interview on 02/24/2026 at 9:22 AM, CNA 2 stated if PPE was not donned appropriately for EBP it placed the resident, other residents and staff at risk for spread of infection. The CNA reported all residents on EBP should not be touched by staff unless staff were wearing gloves and a disposable gown. She said she always tried to don appropriate PPE prior to entering R77's room and knew she should wash or sanitize her hands upon exiting the resident's room. CNA 2 further stated, I must have been in a hurry. I would never put any of my residents at risk for getting an infection or bacteria. 2. Observation of R28's room on 02/23/2026 at 11:36 AM, revealed a nebulizer machine with tubing touching the floor. Per observation, the nebulizer machine was not in use and the nebulizer kit was lying on the ground and not in use or stored in a bag. 3. Observation of R42's room on 02/24/2026 at 11:58 AM, revealed a hand sanitizer machine not working located outside the resident's room. Further observation revealed CNA 4 entering R42's room without washing or sanitizing her hands. 4. Observation of R4's wound care on 02/24/2026 at 1:52 PM, revealed Registered Nurse (RN) 4 changed gloves after touching the inside of R19's wound; however, failed to wash her hands before donning new gloves. 5. Observation of R50's room on 02/24/2026 at 12:12PM, revealed a hand sanitizer machine located outside the resident's room that was not working. Additionally, observation revealed a yellow liquid around the toilet lid, some of which was dried and some was still wet. During interview on 02/24/2026 at 3:12 PM, RN 1 stated all staff had been educated on the facility's infection control policies and an EBP sign on the door indicated that resident was on EBP. RN 1 said all staff were to be aware they were to don the appropriate PPE before providing any type of care for residents on EBP. She reported she monitored staff as she was going down the halls and if staff were identified as not wearing appropriate PPE, she would immediately educate them. RN 1 further stated the Infection Preventionist (IP) completed daily rounds to monitor for infection control measures as well. During interview on 02/24/2026 at 1:46 PM, the IP stated she expected nursing staff to follow the facility's policies regarding PPE and EBP. She said if she saw any staff not following proper infection control procedures, she immediately provided them education on what they were doing wrong, and what corrective actions were needed. The IP reported following infection control policies and procedures for a resident on EBP was important to prevent other residents or staff from being exposed to infection. She explained it was important to use good hand hygiene after providing resident care, and upon exiting a resident's room. The IP said she tried to make daily rounds and educate staff regarding (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	infection control procedures as needed. She further stated per facility policy, all nebulizer tubing was to be stored in a bag at the resident's bedside when not in use. During interview on 02/24/2026 at 2:32 PM, the Administrator stated general hand washing was number one, and donning PPE as indicated was expected of all staff. She said she left it to the clinical management staff to make rounds to ensure there were no infection control concerns. The Administrator explained the facility policy was that all nebulizer tubing was to be stored in a bag, and that was her expectation. She further stated she expected all staff to follow the facility's infection control policies.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and facility policy review, it was determined the facility failed to provide housekeeping services to ensure a clean and sanitary environment for 5 of 41 sampled residents, (Resident (R)3, R36, R51, R100, R181). The findings include: Review of the facility policy titled, Resident Rights, undated, revealed the residents had a right to a safe, clean, comfortable and homelike environment. 1. Observation on 02/24/2026 at 11:48AM, of R36's room, revealed a cracked tile on the floor next to the baseboard on the wall. Further observation revealed the toilet paper holder in the bathroom was broken, and had a sharp edge. 2. Observation on 02/24/2026 at 11:58 AM, of R51's room, revealed a black stain around the toilet. In interview with R51, at the time of observation, the resident stated That stain has been there ever since I have been here. I don't like it, but I never complain. I've tried to clean it up but they won't let me. 3. Observation on 02/24/2026 at 12:18 PM, of R100's room, revealed a broken toilet paper holder with a sharp edge. 4. Observation on 02/24/2026 at 12:26 PM, of R181's room, revealed a broken toilet paper holder with a sharp edge. 5. Observation on 02/24/2026 at 12:34 PM, on the 200 hallway, revealed a broken wall bumper with a sharp edge. 6. Observation on 02/24/2026 at 12:42 PM, on the 300 hallway, revealed a broken wall bumper in the hallway and one next to the dining room. 7. Observation on 02/24/2026 at 12:58 PM, of R3's bathroom, revealed two bedpans stored lying on top of a black bag. Continued observation revealed one bedpan was not covered and had a yellow liquid in it. 8. Observation on 02/24/2026 at 1:08 PM, of the 200 hall men's shower room, revealed hair, nail clippings, and a brown substance underneath the shower mat on the shower bed. 9. Observation on 02/24/2026 at 1:19 PM, of the 300 hall men's shower room, revealed hair, nail clippings, and a dry white non-odorous substance underneath the shower mat on the shower bed. Per request of the State Survey Agency (SSA) Surveyor, the Director of Nursing (DON) came into the shower room and was shown the underneath of the shower mat. In interview at the time of the observation, the DON stated, That is filthy and I will take care of it now. In interview on 02/25/2026 at 11:42AM, the Maintenance Director stated they expected staff to notify maintenance of any issues needing to be fixed. He said there was a facility form staff could fill out and we will get it taken care of. The Maintenance Director reported there were no current active work orders and he had not been made aware of anything needing to be fixed at that time. He stated, As of right now, I don't know of anything that would need fixed. We try to do a walk through of the facility at least on a weekly basis to check for issues that may need to be fixed and nobody has reported it to us. In an additional interview on 02/25/2026 at 1:14 PM, the DON stated all residents deserved to have a clean and sanitary environment that made them feel comfortable. She said, We all love these residents here. If there is something that needs to be repaired or just something a resident wants, we encourage them to let us know so that we can help to get it taken care of. The DON stated there should not be any broken tiles or broken wall bumpers in the facility. She further stated if there were such issues maintenance should be checking into it. During interview with the Housekeeping Manager on 02/25/2026 at 1:12 PM, she stated, Each resident room will get a deep clean a few times a week. She reported she instructed her staff to report anything needing to be fixed or repaired to her or to maintenance so the issue could be fixed/repaired. The Housekeeping Manager said, They all know we are supposed to report anything that needs repaired, to maintenance. That is my expectation of all my staff in housekeeping. This is also the expectation of the DON and Administrator. In interview on 02/25/2026 at 1:49 PM, the Administrator stated, We are big on resident satisfaction here. If something needs to be fixed, we will fix it. Residents deserve to have a homelike environment. It is my expectation that maintenance will repair anything in the facility that needs to be fixed. The Administrator further stated the facility had a maintenance form that could be filled out by any staff member in the facility and maintenance would prioritize those and fix the problem.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policies, the facility failed to ensure residents had the right to privacy in their use of electronic social [NAME] communication for 1 of 41 residents (Resident (R)151). The findings include: Review of the facility's, Resident Rights packet (provided by the Kentucky State Long-Term Care Ombudsman Program to the facility), copyright 2022, revealed residents had a right to privacy and confidentiality including the right to privacy in using electronic communications. Review of R151's admission Record Sheet revealed the facility admitted the resident on 06/09/2021, with diagnoses which included diabetes, cerebral infarction, major depressive disorder, hemiplegia and hemiparesis, and anxiety. Review of the facility's Quarterly Minimum Data Set (MDS) Assessment revealed the facility assessed R151 as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition Review of the Social Service Note for R151, dated 02/09/2026 as a late entry for 01/20/2026, documented by the Social Services Director (SSD), revealed per administration's request, she (SSD) encouraged R151 to consider removing a personal social media post. Further review revealed R151 pulled (took down) the social media post up on her phone and the SSD assisted the resident in deleting the post. During interview, on 02/25/2026 at 3:48 PM, the SSD stated she had been asked by the Administrator and Regional Nurse to speak to R151 regarding a social media most she made regarding concerns about a fall the resident sustained in the facility. She said she did not really look at it (the post); however, had spoken to R151 regarding the facility's concerns with the post. The SSD reported she was unsure what the Administrator's concerns had been about the post, except for appearances since people know where she lives. She stated R151 showed her the post and said she wanted to delete it if it was causing problems and asked the her (SSD) to show her how to delete it. Additionally, she further stated R151 held her phone the entire time while she (the SSD) assisted her (the resident) in deleting the post. During interview, on 02/25/2026 at 4:10 PM, R151 stated she had made a social media post of herself after a fall in January 2026. She said the SSD, along with other staff, asked her to remove the post, and she told them she did not know how to delete a post; R151 stated the SSD deleted the post for her. She reported the post was only of her own face and did not show any other residents or the name of the facility in the post. R151 further stated she had felt pressured to delete the post by several staff members coming into her room and asking her to do so During interview, on 02/25/2026 at 4:20 PM, the Director of Nursing (DON) stated she had been in R151's room when the SSD discussed a social media post with the resident. She said however, she could not recall what was stated to R151 or what the post was concerning. The DON told the State Survey Agency (SSA) Surveyor to talk with the Administrator as that was who asked the SSD to take down the post. She further stated, if it's not a big deal, I don't put a lot of thought into it. During interview, on 02/26/2026 at 11:40 AM, the Administrator stated she had discussed R151's social media post with the SSD because the resident posted some concerns regarding the care she was receiving (at the facility) on the post. She reported she did not instruct the SSD to have R151 remove the post, just to address the concerns on it regarding the resident's care. The Administrator further stated she could not recall how she was made aware of the social media post in the first place, and R151 had not shared the post with her directly. She further stated she had not saved a copy of the post and could not remember exactly what it stated.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policies, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident to include measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs and describe the services to be furnished to attain or maintain a resident's highest practicable physical, mental, and psychosocial well-being for 3 of 41 sampled residents, (Resident (R)90, R138 and R24). The findings include:: Review of the facility's, Care Plan Policy and Protocol revised in 09/2024, revealed the facility was to develop a comprehensive care plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychosocial needs as identified in a comprehensive assessment. Further policy review revealed the comprehensive care plan in the Electronic Health Record (EHR) shall be periodically reviewed and revised by the interdisciplinary team after each assessment and on an as-needed basis. Review of the facility's, Protocol for Completing Trauma Assessment, developed in 07/2019, revealed it was the facility's process to complete the assessment on admission, and to develop the care plan based on the screening. Continued review revealed if the initial screening was negative (for trauma), but later, there were indicators of past trauma, the resident was to be re-evaluated and referred to psychiatric services at that time, after consultation with the resident's physician. Further review of the Protocol revealed the Trauma Assessment Form was to be completed on the admission and Annual or Significant Change Minimum Data Set (MDS) Assessment. Review of the facility's job description for the MDS Coordinator, revised 09/25/2024, revealed the position was responsible for oversight of the residents' baseline care plans and coordination of the completed comprehensive care plan according to regulatory requirements. Per review, the MDS Coordinator was also responsible for coordinating the input of the interdisciplinary team (IDT) members toward accurate and timely completion of MDS assessments and care plans. Further review revealed the job description described the Licensed Practical Nurse (LPN) MDS Nurse as a secondary position, and the Registered Nurse (RN) MDS position as responsible for the oversight of the (MDS) position. (1) Review of the Face Sheet for R138 revealed the facility originally admitted the resident on 11/21/2024, with diagnoses that included Post Traumatic Stress Disorder (PTSD), Schizoaffective Disorder, Bipolar, Generalized Anxiety Disorder, and Major Depressive Disorder. Review of the facility's Trauma Informed Care Screening, performed on the resident's admission and dated 11/21/2024, revealed R138 was negative for a history of PTSD. Review of the Quarterly MDS Assessment, with an Assessment Reference Date (ARD) of 01/28/2026, revealed the facility assessed R138 to have a Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating she was cognitively intact. Review of the Comprehensive Care Plan (CCP) for R138 revealed an entry dated 05/30/2025, which noted R138 used psychotropic medications and had multiple mental health diagnoses, including PTSD. Further review of the CCP revealed however, no indication of what the PTSD pertained to or what interventions were to be in place to mitigate the potential for further psychosocial trauma. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a clinical note documented by Psychiatric (Psych) Nurse Practitioner (NP) 1, dated 03/06/2025, regarding R138, a diagnosis of PTSD was listed in the note, with childhood sexual abuse identified as the cause of the PTSD. During an interview on 02/24/2026 at 2:12 PM with R138, she confirmed she had a diagnosis of PTSD, which was related to childhood abuse. R138 denied having any specific triggers and did not feel that having male caregivers caused her increased anxiety. During an interview on 02/25/2026 at 2:38 PM, the Social Services Director (SSD) stated she was aware R138 had a diagnosis of PTSD, but she was not sure what the cause was for the diagnosis. She said she thought it might have to do with a family issue at home, as an adult, but stated she would have to ask R138, and she had not previously done that. The SSD reported there had been no further investigation by her regarding R138's PTSD diagnosis or triggers. She further stated the risk of failure to prevent triggers might cause R138 to be retraumatized and could be harmful to the resident's mental health. (2) Observation on 02/23/2026 at 2:45 PM, revealed R90 lying on the bed, with eyes closed, and a sitter at the side of his bed. Further observation revealed a fall mat located on the floor to the left of the bed, with the right side of the bed against the wall. Review of the Face Sheet for R90 revealed the facility admitted the resident on 11/28/2025, with primary diagnoses including: encephalopathy, generalized anxiety, depression, essential tremor, sleep apnea, and hypertension. Continued record review revealed a diagnosis of PTSD had been added on 02/19/2026. Review of the admission MDS Assessment, with an ARD of 12/05/2025, revealed the facility assessed R90 to have a BIMS score of 9 out of 15, indicating moderate cognitive impairment. Further MDS review revealed the facility also assessed R90 to have diagnoses of Anxiety and Depression. In interview on 02/24/2026 at 4:00 PM, R90's family Guardian stated she was the resident's niece, and became his Guardian around 2023. She said R90 had witnessed the death of his father and brother by gunshot and then lost two more siblings due to drowning within less than 10 years. The Guardian reported R90 did not talk much about those deaths; however, on occasion, he said he wished he had gotten to know them better. She explained that after COVID-19, he lost any desire to do anything, and she noticed his overall health had declined. The Guardian stated she was unaware of any specific triggers related to R90's PTSD. She further stated she thought she recalled speaking to someone during R90's admission about his PTSD but could not recall who she talked to. The Guardian additionally said if the PTSD had been discussed with R90, he likely had not understood due to some hearing difficulties he had in crowded areas. In interview on 02/25/2026 at 3:04 PM, Certified Nursing Assistant (CNA) 10 stated the floor staff were made aware of how to care for residents based on the residents' care plan. He said floor staff had the care plan information readily available on the Kardex, which was kept on the unit, in a three-ring binder. After reviewing the Kardex for R90 and R138, CNA 10 stated however, he was unable to identify triggers for PTSD for those residents. He reported he had not been made aware of specific triggers for either R90 or R138, but felt that information would be helpful when providing care for those residents to prevent causing them unnecessary distress. The CNA further stated he was aware of only one resident who was care planned for special care, and that was R111, who was not to have male caregivers and also had a diagnosis of PTSD. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 02/24/2026 at 1:54 PM, Registered Nurse (RN) 8, the Unit Manager (UM), stated a Kardex was a document kept on the floor for staff to use for the resident's latest care plan interventions and orders. She said the Kardex was used as it could have information added to or items removed, since a pencil was used. RN 8/UM stated it was part of her job to ensure what was on the Kardex aligned with the residents' orders and care plans. She reported that those changes were addressed in the facility's morning clinical meetings throughout the week. RN 8/UM explained the official computerized care plan was updated by the MDS Nurse at that time. She stated she was aware R138 and R90 both had a diagnosis of PTSD, but was not aware what either resident's PTSD diagnosis pertained to or what might be triggers for them. She further stated she would like to know that information so those situations could be avoided as they had the potential to create unnecessary distress for the residents. During interview on 02/25/2026 at 3:50 PM, RN/MDS Nurse 2 stated MDS performed the Trauma Informed Care Assessment on residents. She said that the assessment was to be done upon admission and annually thereafter. RN/MDS 2 reported that the interviews for that assessment were done one-on-one, at the resident's bedside, along with the depression assessment and the BIMS assessment. She explained she was not familiar with either resident; however, she did know R138 had a diagnosis of PTSD. RN/MDS 2 said she was not sure why or what triggers might need to be avoided for R138. She stated she had not read the full clinical psych note, and that information had not previously been brought to her attention. RN/MDS 2 explained not knowing what triggers a resident might have for a PTSD diagnosis had the potential to create unnecessary distress for that resident. She further stated as an RN/MDS Nurse it was her responsibility to review and sign off on any work done by the LPN/MDS Nurse, specifically LPN/MDS 2. During interview on 02/26/2026 at 9:45 AM, RN/MDS Nurse 1 stated the Trauma Informed Care Assessment was done on admission, and the Care Plan was entered into the EHR by the MDS nurse. She said if necessary, updates to the care plan could be added to the Kardex at the UM's direction, and then MDS would add those updates to the resident's Care Plan the next workday. RN/MDS Nurse 1 reported she was aware of the PTSD diagnoses for R138 and R90 but did not know what the diagnoses were related to for those residents. She stated she was not aware of specific triggers for either resident; however, she did understand how the potential for unnecessary distress to the residents could occur without that information. RN/MDS Nurse 1 further stated it was the RN/MDS Nurse's responsibility to review and sign off on work performed by the LPN/MDS Nurse, specifically LPN/MDS 1. During interview on 02/26/2026 at 10:12 AM, LPN/MDS Nurse 1, stated she had been trained for the MDS role for three days and then was precepted by RN/MDS Nurse 1. She said she was only familiar with R90 and knew he had a history of PTSD, but she was not aware of what triggers he might have. LPN/MDS Nurse 1 reported R90's Guardian had been interviewed during the first care plan meeting and did not mention any previous traumatic experiences. She stated it was important to know what specific triggers any resident with a diagnosis of PTSD might have, so those situations could be avoided. After review of the residents' care plans, she said staff would not be aware of what, if any, triggers to avoid for residents with PTSD. LPN/MDS Nurse 1 further stated that, as a result, the residents could suffer increased anxiety or unnecessary distress. During interview on 02/24/2026 at 3:45 PM, the Primary Nurse Practitioner (NP) stated she was aware of the PTSD diagnosis for both R90 and R138. She said she knew the history of both residents; however, was unaware of specific triggers for either resident. The Primary NP reported knowing what, if any, triggers were associated with a PTSD diagnosis would be beneficial in providing the best (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185134	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hazard Health and Rehabilitation Center	390 Park Avenue Hazard, KY 41702

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care for those residents. She stated, in regards to R138 specifically, that resident had previously been treated by her current Psych NP 2 and she had requested Psych NP 2 work with the resident again. The Primary NP further stated R138 had briefly been seen by Psych NP 1 during the interim, but returned to the care of Psych NP 2 a couple of weeks ago. She additionally said the records from Psych NP 1 were available in the EHR for review. During interview on 02/24/2026 at 3:55 PM, Psych NP 2 stated she was aware of R138's PTSD diagnosis, and what it pertained to. She said new medications had been initiated for R138; however, the resident had not been using the medications long enough to evaluate their effectiveness. Psych NP 2 stated she was aware of efforts to incorporate talk therapy as well. She further stated knowing PTSD triggers would be beneficial in assessing appropriate care needs of the residents. During interview on 02/25/2026 at 2:53 PM, the Director of Nursing (DON) stated the initial care plans were done upon admission by the MDS Nurses. She said unless a resident's admission was after hours, then the floor nurse would do a baseline care plan, and MDS would review that care plan on the next working day. The DON reported she was aware R138 and R90 both had a diagnosis of PTSD, but she was not sure the reasons why. She explained the UM would be the first to review new clinical notes and address any new orders or new diagnoses, and then that information would be discussed in the morning clinical meetings. The DON verbalized understanding of what PTSD was, and stated it was important to avoid any potential triggers so a resident with that diagnosis did not suffer any additional psychosocial harm. She stated she understood the concern with the missing PTSD part of both residents' care plans she reviewed. The DON further stated she was not aware if that information had been obtained and was unable to explain why the missing information had not been previously caught. During interview on 02/25/2026 at 3:29 PM, the Administrator stated she was not clinical, but she was able to verbalize what PTSD stood for, Post-Traumatic Stress Disorder, which meant the resident had suffered from an event or situation that caused physical or mental trauma. She said it was important to avoid situations that might cause the residents to be re-traumatized. The Administrator stated the nurses should have access to what triggers the resident might have or some type of information regarding the PTSD diagnosis. She further stated not having that information could cause failing health, increased anxiety, depression, or regression for residents with a PTSD diagnosis. She was unable to verbalize why that information had not been included in the residents' care plans reviewed. (3) Review of R24's admission Record revealed the facility admitted the resident on 12/16/2024, with diagnoses which included polyneuropathy, essential tremors, osteoarthritis, and major depressive disorder. Review of R24's Quarterly MDS Assessment, dated 06/20/2025, revealed the facility assessed the resident to have a BIMS score of three out of 15, indicating severe cognitive impairment. Continued review revealed the facility assessed R24 to have diagnoses which included, muscle weakness, difficulty in walking, and lack of coordination. Further MDS review revealed the facility assessed R24 to not have had any falls since admission or for the prior assessment. Review of R24's Quarterly MDS Assessment, dated 09/19/2025, revealed the facility again assessed the resident to have a BIMS score of three out of 15, indicating severe cognitive impairment. Per MDS review, the facility assessed R24 to have had two or more falls with no injury and one fall with major injury (bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hematoma) since the prior MDS Assessment (on 06/20/2025). Review of R24's Care Plan, initiated 01/27/2026, revealed the facility noted the resident was at high risk for falls due to need for activities of daily living (ADL) assistance, medication use, age, and co-morbidities. Continued review revealed the facility developed interventions for non-skid footwear, to check placement of that footwear during rounds and reapply as needed; and provide wheelchair/walker as needed. Further review of the care plan revealed however, no date noted for when those interventions were implemented. Additional review revealed the only intervention dated was an intervention for scheduled toileting which was noted as resolved on 11/20/2025. Review of the facility's Fall Investigations for R24 revealed the resident sustained a fall on 08/18/2025, and the facility implemented an intervention for non-skid footwear for R24. Per continued review of the Fall Investigations, R24 experienced another fall on 08/26/2025, and the facility implemented an intervention to give the resident a rolling walker. Further review of the Fall Investigations revealed R24 again fell on [DATE], while ambulating without a walker and wearing sandals which slipped off her foot, and sustained a dislocated shoulder. In addition, review of the Fall Investigations revealed R24 sustained another fall on 11/11/2025, while wearing one shoe with the root cause analysis noted as improper footwear. Review of the Fall Investigations also revealed R24 experienced another fall on 11/17/2025, when the facility assessed R24 to have failed to use her walker. During interview, on 02/25/2025 at 3:25 PM, the LPN/MDS Nurse stated she was responsible for ensuring residents' care plan interventions were transferred to their comprehensive care plan. She further stated the care plan was important for letting staff know how to care for residents. During interview, on 02/26/2025 at 10:10 AM, the RN/MDS Nurse stated she was responsible for making sure R24's care plans were updated with appropriate interventions. She said the Unit Coordinator investigated residents' falls and ensured an appropriate intervention was implemented after each fall. The RN/MDS Nurse explained she placed the Unit Coordinator's intervention onto the residents' comprehensive care plan. She stated R24 already had comprehensive care plan interventions in place for non-skid footwear and a rolling walker when she fell on [DATE], 11/11/2025, and 11/17/2025; however, staff were not following the resident's interventions appropriately. Additionally, she stated the Unit Coordinator was responsible for monitoring the effectiveness of new fall care plan interventions.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility documentation and policy, the facility failed to revise the comprehensive person-centered care plan for 1 of 41 sampled residents, (Resident (R)24) The findings include: Review of the facility's policy, Care Plan Policy and Protocol, revised 09/2024, revealed the facility would develop a comprehensive care plan for each resident that included measurable objectives and timetables. Further review revealed the comprehensive care plan was to be periodically reviewed and revised by the interdisciplinary team (IDT) after each assessment and on an as needed basis. Review of the facility's job description for the, Minimum Data Set (MDS) Coordinator, revised 09/25/2024, revealed the position was responsible for the coordination of the completed comprehensive care plan according to regulatory requirements. Review of the admission Record for R24 revealed the facility admitted her on 12/16/2024, with diagnoses that included polyneuropathy, osteoarthritis, and essential tremors. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/20/2025, revealed the facility assessed R24 as having a Brief Interview for Mental Status (BIMS) score of three out of 15, indicating severe cognitive impairment. Further MDS review revealed the facility also assessed R24 to have diagnoses of muscle weakness, difficulty in walking, and lack of coordination, and to have had no falls since the admission or prior assessment. Review of the Quarterly MDS Assessment, dated 09/19/2025, revealed the facility assessed R24's BIMS score to continue to be three out of 15, indicating severe cognitive impairment. Continued MDS review revealed the facility assessed R24 to have had 2 or more falls with no injury and 1 fall with major injury (bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma) since the prior assessment (on 06/20/2025). Review of the Care Plan, initiated 01/27/2026, revealed the facility noted R24 was at high risk for falls due to age, co-morbidities, and need for assistance with activities of daily living (ADL). Per care plan review the interventions included non-skid footwear; however, there was no date for when that intervention was implemented. Review of the facility's Fall Investigations for R24 revealed the resident sustained a fall on 08/18/2025 and the facility implemented an intervention for non-skid footwear for the resident. However, continued review of the Fall Investigations revealed R24 experienced a fall on 10/31/2025, while ambulating with improper footwear (sandals) which slipped off her foot, and not the facility's intervention for ensuring the resident had on the non-skid footwear. During interview, on 02/26/2025 at 10:10 AM, the Registered Nurse (RN)/MDS Nurse stated she was responsible for making sure R24's care plans were updated with appropriate interventions. She said the Unit Coordinator investigated residents' falls and ensured an appropriate intervention was implemented after each fall. The RN/MDS Nurse stated she then placed the Unit Coordinator's intervention onto the comprehensive care plan. She further stated R24 had a comprehensive care plan intervention in place for non-skid footwear when she fell on [DATE] and the resident's comprehensive care plan was not revised with a new intervention. RN/MDS Nurse additionally said the Interdisciplinary Team (IDT) met every Friday to discuss every fall that had occurred during that week.