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

PRINTED: 09/09/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185166	B. WING			C 09/03/2020		
NAME OF PROVIDER OR SUPPLIER HARLAN HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEDICAL CENTER DRIVE HARLAN, KY 40831	TREET ADDRESS, CITY, STATE, ZIP CODE 00 MEDICAL CENTER DRIVE			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	IX (EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE		
F 000	a COVID-19 focused conducted on 09/03/2 unsubstantiated and identified. The facilit compliance with 42 0 and has implemented	dard survey (KY32273) and infection control survey was 2020. The complaint was no deficient practice was y was found to be in CFR 483.80 Infection Control d the Centers for Medicare & CMS) and Centers for Prevention (CDC) ces to prepare for	F	000				
LABORATORY	DIRECTOR'S OR PROVIDER	USUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE		

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

PRINTED: 09/09/2020 FORM APPROVED Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WNG_ 100510 09/03/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 MEDICAL CENTER DRIVE HARLAN HEALTH AND REHABILITATION CENTER HARLAN, KY 40831 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 000 N 000 Initial Comments A complaint investigation (KY32273) and a COVID-19 focused infection control survey was conducted on 09/03/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE

LVSF11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED			
		185166	B. WING		- 3	03/2020			
	ROVIDER OR SUPPLIER	LITATION CENTER	200	STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEDICAL CENTER DRIVE HARLAN, KY 40831					
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE			
E 000	A COVID-19 focus survey was conduct facility was found to CFR 483.73 Emerg	ed Emergency Preparedness sted on 09/03/2020. The poly be in compliance with 42 gency Preparedness related to ant practice was identified.	€ 000						
LABORATORY	OIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGNATU	JRE	TITLE		(X6) DATE			

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