DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		185166	B. WING			01/	19/2021
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	200 MEDICAL CENTER DRIVE		
	HARLAN HEALTH AND REHABILITATION CENTER			HARLAN, KY 40831			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
1/10					DEFICIENCY)		
F 000	INITIAL COMMENTS A COVID-19 focused conducted on 01/19/2 to be in compliance w Control and has imple Medicare & Medicaid Centers for Disease ( (CDC) recommended	infection control survey was 2021. The facility was found with 42 CFR 483.80 Infection emented the Centers for Services (CMS) and Control and Prevention practices to prepare for ent practice was identified.		000	DEFICIENCY)		
		SUPPLIER REPRESENTATIVE'S SIGNATUR	) ) – – – – – – – – – – – – – – – – – –		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: 02/02/2021

		D HUMAN SERVICES			FORM APPE	ROVED
STATEMENT C	CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:				OMB NO. 0938 (X3) DATE SURVEY COMPLETED	
		185166	B. WING _		01/19/2021	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	-	
				200 MEDICAL CENTER DRIVE		
HARLAN	IEALTH AND REHABILI			HARLAN, KY 40831		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMP D THE APPROPRIATE D/	(5) LETION ATE
E 000	Initial Comments		EC	000		
	survey was conducted facility was found to b CFR 483.73 Emerger	Emergency Preparedness d on 01/19/2021. The e in compliance with 42 ncy Preparedness related to bractice was identified.				
		SUPPLIER REPRESENTATIVE'S SIGNATU		TITLE	(X6) DAT	

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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## PRINTED: 02/09/2021 FORM APPROVED

Office of Inspector General           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:           100510			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED 01/19/2021	
		B. WING				
	ROVIDER OR SUPPLIER HEALTH AND REHABIL	STREET A 200 MEE	DDRESS, CITY, STATE, DICAL CENTER DRI J, KY 40831	ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN PREFIX (EACH CORRECTIVE TAG CROSS-REFERENCED			
N 000	conducted on 01/19/	d infection control survey was /2021. The facility was found pursuant to 42 CFR 483.80. a was identified.	N 000			

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