		ND HUMAN SERVICES			FORM APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		185166	B. WING		06/03/202 <u>0</u>	
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
HARLAN	HEALTH AND REHABIL	ITATION CENTER		RLAN, KY 40831		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE	
F 000	INITIAL COMMENTS	5	F 000			
F 880 SS=D	conducted on 06/03/ to be out of compliar Infection Control. De identified with the hig "D" level. The total of Infection Prevention CFR(s): 483.80(a)(1 §483.80 Infection Co The facility must esta infection prevention designed to provide comfortable environe development and tra diseases and infection program. The facility must esta and control program	yhest scope and severity at census was 140. & Control (2)(4)(e)(f) ablish and maintain an and control program a safe, sanitary and ment and to help prevent the nsmission of communicable ons. prevention and control ablish an infection prevention (IPCP) that must include, at	F 880			
	reporting, investigati and communicable of staff, volunteers, visi providing services un arrangement based conducted according accepted national sta	em for preventing, identifying, ng, and controlling infections liseases for all residents, tors, and other individuals nder a contractual upon the facility assessment t to §483.70(e) and following				
	procedures for the p but are not limited to (i) A system of surve possible communica	rogram, which must include, : illance designed to identify ble diseases or				
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	(X6) DATE	

Electronically Signed

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: 06/29/2020

		ND HUMAN SERVICES			PRINTED: 06/29/2020 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED		
		185166	B. WING		06/03/2020
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
HARLAN HEALTH AND REHABILITATION CENTER			0 MEDICAL CENTER DRIVE ARLAN, KY 40831		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 880	Continued From pag	je 1	F 880		
	infections before the persons in the facility	ey can spread to other y;			
		om possible incidents of ase or infections should be			
	to be followed to pre	ensmission-based precautions event spread of infections; solation should be used for a			
	resident; including b				
	depending upon the involved, and	infectious agent or organism			
		at the isolation should be the sible for the resident under the			
	(v) The circumstance	es under which the facility yees with a communicable			
	disease or infected s	skin lesions from direct ts or their food, if direct			
	(vi)The hand hygiene	e procedures to be followed lirect resident contact.			
		tem for recording incidents facility's IPCP and the ken by the facility.			
		dle, store, process, and is to prevent the spread of			
		eview. uct an annual review of its eir program, as necessary.			
	by:	T is not met as evidenced on, interview, record review,			

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If continuation sheet Page 2 of 6

CENTERS FOR MEDICARE & MEDICAID SERVICES	OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULT         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDI	PLE CONSTRUCTION     (X3) DATE SURVEY       G     COMPLETED
185166 B. WING	06/03/2020
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARLAN HEALTH AND REHABILITATION CENTER	200 MEDICAL CENTER DRIVE HARLAN, KY 40831
(X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFI       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
F 880       Continued From page 2 review of Centers for Disease Control and Prevention (CDC) guidelines, and review of the facility's policy, it was determined the facility failed to properly prevent and/or contain COVID-19 for one (1) of five (5) sampled residents (Resident #1). Resident #1 was recently admitted to the facility after being hospitalized and was residing on the facility's COVID-19 Unit. Observation on 06/03/2020 at 9:15 AM, revealed Resident #1 was observed on an ambulance stretcher being transferred from the facility's COVID-19 care unit to the dialysis clinic. The ambulance crew parked the stretcher with Resident #1 at the Rosewood Place nursing station to talk to the nursing staff. Resident #1 was not observed to have on a face mask. Prior to the ambulance service leaving from the nurses' station Registered Nurse (RN) #1 placed a face mask on the resident.         The findings include:         Review of the facility's policy titled, "Protocol: COVID-19," with a revision date of 04/01/2020, revealed all residents would be monitored daily for symptoms of COVID-19. Monitoring would include daily oxygen saturation and lung sounds. The policy also revealed that the CDC guidelines for identifying, monitoring, and treating residents with COVID-19 would be followed. The facility's Infection Preventionist would check the CDC's website on a daily basis for any updates regarding COVID-19.         Review of the CDC's COVID-19 guidelines for new admissions titled, "Responding To Coronavirus (COVID-19) in Nursing Homes," dated 2019, revealed if the resident must leave his/her room, they must reinforce adherence to universal source control policies and social	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/29/2020 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		185166	B. WING		06/03/2020
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
HARLAN	HEALTH AND REHABIL	TATION CENTER		00 MEDICAL CENTER DRIVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 880	face covering or face six (6) feet away from room. The guideline be monitored for evic fourteen (14) days at using all recommend protective equipment Observation of Resid 9:15 AM, revealed th the ambulance streto the facility's COVID- clinic. The ambulance with Resident #1 at t station to talk to the n was not observed to to the ambulance set station Registered N to place a face mask Review of Resident # the facility admitted t with diagnoses inclue Disease, which requi Obstructive Pulmona Mellitus. The Minimu assessments had no Review of Resident # 05/29/2020, revealed been developed for i COVID-19, for conta fourteen (14) days. I plan revealed the car interventions that rec (mask, gloves, and g	ave the resident wear a cloth e mask and remain at least in others when outside their is state new residents should dence of COVID-19 for fter admission and cared for led COVID-19 personal t (PPE). dent #1 on 06/03/2020 at he resident was observed on the Rosewood Place nursing mursing staff. Resident #1 have on a face mask. Prior rvice leaving from the nurses' urse (RN) #1 was observed on the resident. #1's medical record revealed he resident on 05/29/2020, ding End Stage Renal ires Hemodialysis, Chronic ary Disease, and Diabetes um Data Set (MDS) t yet been completed. #1's baseline care plan dated d care plan interventions had infection related to ct/droplet precautions for Review of the baseline care	F 880		

Facility ID: 100510

If continuation sheet Page 4 of 6

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED          185166       B. WING       06/03/202         NAME OF PROVIDER OR SUPPLIER       B. WING       06/03/202         HARLAN HEALTH AND REHABILITATION CENTER       B. WING       06/03/202         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION OF CORRECTION OF CORRECTION SHOULD BE       (200 MEDICAL CENTER DRIVE         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION OF CORRECTION OF CORRECTION SHOULD BE       (200 MEDICAL CORRECTIVE ACTION SHOULD BE			ND HUMAN SERVICES MEDICAID SERVICES			FORM	06/29/2020 APPROVED 0938-0391
NME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       HARLAN HEALTH AND REHABILITATION CENTER     200 MEDICAL CENTER DRIVE HARLAN, KY 40831       (M) ID PREFIX     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG     D D RECULATORY OR LSC DENTERTING INFORMATION)     D D RECOVER DEFICIENCY TAG     D D RECOVER DEFICIENCY (EACH CORRECTIVE ACTION BHOODERS (EACH CORRECTIVE ACTION BHOODERS DEFICIENCY)     Construction (EACH CORRECTIVE ACTION BHOODERS (EACH CORRECTIVE ACTION BHOODERS (			. ,		(X3) DATE SURVEY COMPLETED		
HARLAN HEALTH AND REHABILITATION CENTER         200 MEDICAL CENTER DRIVE HARLAN, KY 40831           (xi) ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D PREFIX TAG         PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH ODRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE         00 CROSS-REFERENCE) TO THE APPROPRIATE         00 CROSS-REFERENCE) TO THE APPROPRIATE         00 DEFICIENCY           F 880         Continued From page 4         F 880         F 880         F 880           Review of physician's orders for Resident #1 revealed an order dated 06/02/2020, for the resident to attend dialysis clinic.         F 880         F 880           Interview conducted with Registered Nurse (RN) #1 on 06/03/2020 at 9:25 AM, revealed all residents coming out of the facility was required to wear a face mask. RM #1 stated Resident #1 should have been wearing a face mask before he/she left his/her room.         Interview with State Registered Nursing Assistant (SRNA) #1 on 06/03/2020 at 9:33 AM, revealed she assisted SRNA #2 with transferring Resident #1 from his/her bed over to the ambulance stretcher. The SRNA stated he resident had asked them to wait a minute prior to placing the mask on the resident. The SRNA stated she should have either waited and placed			185166	B. WING		06/0	3/2020
HARLAN HEALTH AND REHABILITATION CENTER       HARLAN, KY 40831         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       IPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SYOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       0.00M (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 880       Continued From page 4       F 880         Review of physician's orders for Resident #1 revealed an order dated 06/02/2020, for the resident to attend dialysis on Mondays, Wednesdays, and Fridays at the dialysis clinic.       F 880         Interview conducted with Registered Nurse (RN) #1 on 06/03/2020 at 9:25 AM, revealed all residents coming out of the facility was required to wear a face mask. RN #1 stated Resident #1 should have been wearing a face mask before he/she left his/her room.       Interview with State Registered Nursing Assistant (SRNA) #1 on 06/03/2020 at 9:33 AM, revealed she assisted SRNA #2 with transferring Resident #1 from his/her bed over to the ambulance stretcher. The SRNA stated the resident had asked them to wait a minute prior to placing the mask on the resident. The SRNA stated she should have either waited and placed	NAME OF PI	ROVIDER OR SUPPLIER					
PREFIX TAG       (EACH DEFICIENCY MUST EE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       construction         F 880       Continued From page 4       F 880         Review of physician's orders for Resident #1 revealed an order dated 06/02/2020, for the resident to attend dialysis on Mondays, Wednesdays, and Fridays at the dialysis clinic.       F 880         Interview conducted with Registered Nurse (RN) #1 on 06/03/2020 at 9:25 AM, revealed all residents coming out of their rooms on the COVID-19 Unit were required to don a face mask prior to leaving their room. The RN stated any resident going out of the facility was required to wear a face mask before he/she left his/her room.       Interview with State Registered Nursing Assistant (SRNA) #1 on 06/03/2020 at 9:33 AM, revealed she assisted SRNA #2 with transferring Resident #1 from his/her bed over to the ambulance stretcher. The SRNA stated the resident had asked them to wait a minute prior to placing the mask on the resident. The SRNA stated she should have either waited and placed	HARLAN	HEALTH AND REHABIL	TATION CENTER				
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revealed an order dated 06/02/2020, for the resident to attend dialysis on Mondays, Wednesdays, and Fridays at the dialysis clinic. Interview conducted with Registered Nurse (RN) #1 on 06/03/2020 at 9:25 AM, revealed all residents coming out of their rooms on the COVID-19 Unit were required to don a face mask prior to leaving their room. The RN stated any resident going out of the facility was required to wear a face mask. RN #1 stated Resident #1 should have been wearing a face mask before he/she left his/her room. Interview with State Registered Nursing Assistant (SRNA) #1 on 06/03/2020 at 9:33 AM, revealed she assisted SRNA #2 with transferring Resident #1 from his/her bed over to the ambulance stretcher. The SRNA stated the resident had asked them to wait a minute prior to placing the mask on the resident. The SRNA stated she should have either waited and placed	F 880	Continued From pag	e 4	F 880			
<ul> <li>nurse. The SRNA stated she had been trained to ensure a mask was placed on residents prior to them leaving the facility.</li> <li>Interview conducted with SRNA #2 on 06/03/2020 at 10:04 AM, revealed she had attempted to place a face mask on Resident #1 and the resident had asked her to wait. The SRNA stated she was required to notify the nurse and should have notified the nurse that the resident did not want to wear the face mask. The SRNA stated she then went with SRNA #1 to assist another</li> </ul>		revealed an order da resident to attend dia Wednesdays, and Fr Interview conducted #1 on 06/03/2020 at residents coming out COVID-19 Unit were prior to leaving their resident going out of wear a face mask. F should have been we he/she left his/her ro Interview with State I (SRNA) #1 on 06/03, she assisted SRNA # #1 from his/her bed of stretcher. The SRN/ asked them to wait at mask on the resident went to assist another stated she should hat the mask on Resider nurse. The SRNA st ensure a mask was p them leaving the faci Interview conducted at 10:04 AM, revealed place a face mask or resident had asked f she was required to have notified the nur want to wear the faci	ted 06/02/2020, for the ilysis on Mondays, idays at the dialysis clinic. with Registered Nurse (RN) 9:25 AM, revealed all of their rooms on the required to don a face mask room. The RN stated any the facility was required to RN #1 stated Resident #1 earing a face mask before om. Registered Nursing Assistant 2020 at 9:33 AM, revealed 42 with transferring Resident over to the ambulance A stated the resident had minute prior to placing the the resident. The SRNA ve either waited and placed at #1 or reported it to the ated she had been trained to oblaced on residents prior to lity. with SRNA #2 on 06/03/2020 d she had attempted to n Resident #1 and the ter to wait. The SRNA stated notify the nurse and should se that the resident did not e mask. The SRNA stated				

Facility ID: 100510

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
185166 NAME OF PROVIDER OR SUPPLIER		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		06/03/202 <u>0</u>	
HARLAN HEALTH AND REHABILITATION CENTER				200 MEDICAL CENTER DRIVE HARLAN, KY 40831	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 880	revealed residents o encouraged to stay i face mask when out Preventionist stated the facility for appoin required to don a face of their room. The Ir she monitored daily were donning approp identified any concer Preventionist stated been wearing a face room. Interview conducted (DON) on 06/03/202 resident coming out COVID-19 Unit was	with the Infection 03/2020 at 10:30 AM, n the COVID-19 Unit are n their room and to don a of their room. The Infection all residents going to out of thements or dialysis were are mask prior to coming out offection Preventionist stated to ensure staff and residents oriate PPE and had not rns. The Infection Resident #1 should have mask prior to leaving his/her with the Director of Nursing 0 at 11:25 AM, revealed any of their room on the required to don/wear a face	F 88	30	
	the SRNA was requi nurse. The DON sta have been taken out	efused to wear a face mask, red to immediately notify the ited Resident #1 should not of his/her room without . The DON stated the facility nes for isolation.			

If continuation sheet Page 6 of 6

PRINTED: 06/29/2020

	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			(X2) MULTIPLE CC A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
185166 NAME OF PROVIDER OR SUPPLIER		B. WING	06/03/202 <u>0</u>			
HARLAN H	IEALTH AND REHAB	ILITATION CENTER		MEDICAL CENTER DRIVE		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTI	ON (X5)	
PREFIX TAG	(EACH DEFICIE	INCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
E 000	Initial Comments		E 000			
	survey was conduct facility was found t CFR 483.73 Emerge	sed Emergency Preparedness cted on 06/03/2020. The o be in compliance with 42 gency Preparedness related to nt practice was identified.				
		ER/SUPPLIER REPRESENTATIVE'S SIGNATU		TITLE	(X6) DATE	

Electronically Signed

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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Office of Inspector General						
				(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING:		
		100510	B. WING		06/03/202 <u>0</u>	
NAME OF PI	ROVIDER OR SUPPLIER	STF	REET ADDRESS, CITY, STA	ATE, ZIP CODE		
HARLAN I	HEALTH AND REHABIL	ITATION CENTER	) MEDICAL CENTER I RLAN, KY 40831	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETE	
N 000	Initial Comments		N 000			
		d infection control survey wa /2020. Deficient practice wa o 42 CFR 483.80.				
	DIRECTOR'S OR PROVIDER	X/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE	

6899