

PRINTED: 09/25/2014
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185166	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2014
NAME OF PROVIDER OR SUPPLIER HARLAN HEALTH & REHABILITATION CENTER		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 "REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and a review of medical records, care plans, and facility policies, it was determined the facility failed to develop and/or revise a comprehensive care plan that addressed interventions related to pain for one (1) of twenty-four (24) sampled residents (Resident #1). Review of documentation</p>	F 279	- See Attachment -	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maid Hershey TITLE: Administrator (X8) DATE: 10/3/2014

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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F 279	<p>Continued From page 1</p> <p>revealed Resident #1 voiced complaints of pain on a frequent basis and received pain medications. However, review of the resident's comprehensive care plan revealed facility staff failed to ensure a care plan with interventions and measurable objectives had been developed to address the resident's complaints of pain and use of pain medication.</p> <p>The findings include:</p> <p>A review of the facility's policy entitled "Care Plan Policy and Protocol," not dated, revealed the facility would develop a comprehensive care plan for each resident that included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 05/24/13 with diagnoses of Morbid Obesity, Cerebrovascular Accident (CVA), Hemiplegic Affect, Hypertension, Malaise and Weakness, and Depression.</p> <p>Review of the Physician Orders dated 04/18/14 through September 2014 revealed the physician had prescribed 7.5/325 milligrams (mg) of Norco (opioid analgesic) every 8 hours "as needed" for the resident's complaints of pain.</p> <p>Review of the Medication Administration Record (MAR) for April 2014 through 09/11/14 revealed facility staff had administered the prescribed pain medication to Resident #1 on a frequent basis due to the resident's complaints of pain.</p> <p>Review of the quarterly Minimum Data Set (MDS)</p>	F 279		

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F 279	Continued From page 2 assessment dated 08/05/14 revealed Resident #1 rated his/her pain a "7." Review of the Numeric Rating Scale utilized by the facility to assess the level of pain experienced by a resident revealed "0" indicated no pain and "10" was the "worst pain you can imagine." Continued review of the quarterly Minimum Data Set (MDS) assessment dated 08/05/14 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident's cognition was moderately impaired. Interview with Resident #1 on 09/10/14 at 9:30 AM confirmed he/she experienced generalized pain on a daily basis. However, review of Resident #1's comprehensive care plan dated 08/19/14 revealed facility staff failed to develop a care plan, with interventions and measurable objectives, to address the resident's frequent complaints of pain. Interview with the MDS Coordinator on 09/11/14 at 10:07 AM revealed staff that completed the MDS assessments were to compare each resident's diagnoses with the medications prescribed by the physician to ensure problems and interventions related to the medications were added to the care plans. Interview with Registered Nurse (RN) #1 on 09/10/14 at 2:20 PM revealed she had completed the MDS assessment of Resident #1 on 08/19/14. RN #1 stated she should have updated the resident's care plan and identified interventions to address the resident's pain. However, according to RN #1, she must have	F 279		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2014
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F 468	Continued From page 4 order request or "CQI" referral form and give to the appropriate department. Observations conducted on 09/11/14 on the Beach Lane hallway revealed the handrail between the nurses' station and room 309 was loose from the wall. In addition, observations conducted on the Wildcat Drive hallway revealed the handrail between the nurses' station and room 106 was loose from the wall. Continued observation of the Wildcat Drive hallway revealed the handrails between rooms 102 and 103, and between room 103 and the Activities Room were loose and not securely fastened to the wall. Interview with the Maintenance Director on 09/11/14 at 2:20 PM revealed he checked handrails on a weekly basis and Administrative staff and the Continuous Quality Improvement personnel also discussed needed repairs during weekly meetings. The Maintenance Director stated when he received reports for loose handrails he, or Maintenance staff, immediately made repairs to the areas reported. The Maintenance Director stated handrails should be secured to the wall for resident safety; however, the Maintenance Director stated he was not aware of the loose sections of handrails. Interview with the Administrator on 09/11/14 at 1:50 PM revealed the Administrator was unaware of the loose handrails in the facility. According to the Administrator, staff was responsible to notify maintenance staff of needed repairs either verbally or by completion of a maintenance request form, and the Maintenance Director was to ensure the repairs were completed.	F 468		

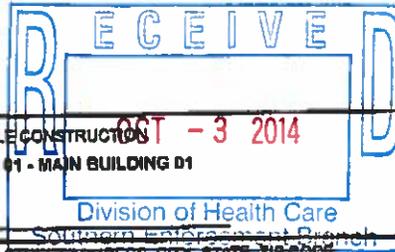
Harlan Health and Rehabilitation Center**Annual survey September 09-11, 2014****Plan of Correction****F 279**

1. The care plan for resident #1 was reviewed and immediately updated to include a comprehensive plan that addresses pain and any needs or problems identified related to pain. The plan implemented included interventions with measurable objectives so that progress and overall effectiveness of the plan may be evaluated.
2. All residents' care plans were reviewed by the MDS Coordinators to ensure a comprehensive care plan was in place for each resident. The review was specific regarding any issues with pain to ensure problems were identified and included interventions with measurable objectives.
3. An in-service was conducted on September 26th, 2014 with the Clinical and MDS Coordinators on the facility's pain policy and the importance of having a comprehensive care plan that addresses all resident needs as identified during the comprehensive assessment. This in-service was provided by the Administrator and Director of Nursing.
4. The CQI committee member designee will perform 6 chart audits per week for 1 month and then 6 charts per month for 3 months to ensure a comprehensive care plan is in place and that all needs have been identified and are being met appropriately. Any irregularities will be corrected immediately and reported to the CQI committee for further review.
5. Completion Date: September 26, 2014.

Harlan Health and Rehabilitation Center**Annual Survey September 09-11, 2014****Plan of Correction****F 468**

1. The handrail on Beach Lane between the nurses' station and room 309 and the handrails on Wildcat Drive between the nurses' station and room 106, between rooms 102 and 103 and between room 103 and the activities room were immediately tightened. Butterfly anchors were used as well as anchoring into as many metal studs as possible for added security/stability.
2. All handrails in the facility were checked to ensure there were no other loose handrails.
3. The Director of Maintenance was in-serviced on September 11, 2014 by the Administrator to conduct walking rounds throughout the facility weekly to observe for loose handrails and if any are found to repair immediately. All other staff were in-serviced on September 19, 2014, regarding utilization the CQI forms for maintenance repair if they observe a loose handrail.
4. The CQI committee member designee will observe for loose handrails weekly for 1 month and then quarterly for 6 months. Any irregularities found will be corrected immediately and reported to the CQI committee for further follow-up.
5. Completion Date: September 19, 2014

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NAME OF PROVIDER OR SUPPLIER HARLAN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEDICAL CENTER DRIVE HARLAN, KY 40831
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1978</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 111 (000)</p> <p>SMOKE COMPARTMENTS: 7</p> <p>FIRE ALARM: Complete automatic fire alarm system.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet & dry) sprinkler system.</p> <p>GENERATOR: Type II diesel generator.</p> <p>A life safety code survey was initiated and concluded on 09/09/14. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "E" level.</p>	K 000		
K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire</p>	K 029	- See Attachment -	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paul Newberry TITLE: Administrator (X6) DATE: 10/3/2014

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K 029	<p>Continued From page 1</p> <p>extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that hazardous area doors were maintained as required. This deficient practice affected one (1) of seven (7) smoke compartments, staff, and other occupants of the building. The facility has the capacity for 143 beds with a census of 138 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 09/09/14 at 11:25 AM, with the Director of Maintenance (DOM), a corridor door to the Nurse Supply room was observed to have a magnetic door hold-open device. Hazardous area doors cannot be held open unless connected to the fire alarm system. The adjacent Housekeeping supply room did not have a door closure installed as well. Doors to hazardous areas are required to have a door-closing device.</p> <p>During the survey, the Mechanical room door was also observed to be held open in an unapproved</p>	K 029	

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K 029	Continued From page 2 manner. An interview with the DOM on 09/09/14 at 11:25 AM revealed he was not aware of the requirements pertaining to hazardous area doors. The findings were revealed to the Administrator upon exit. Referenca: NFPA 101 (2000 Edition). 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.	K 029		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure that sprinkler heads were maintained as required. This deficient practice affected three (3) of seven (7) smoke compartments, staff, and approximately	K 062	- See Attachment -	

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K 062	Continued From page 3 fifty-seven (57) residents. The facility has the capacity for 143 beds with a census of 138 on the day of the survey. The findings include: During the Life Safety Code survey on 09/09/14 at 12:35 PM with the Director of Maintenance (DOM), a white substance was observed on a sprinkler head in resident room 808. Sprinkler heads must be properly maintained to ensure proper operation. An interview with the DOM on 09/09/14 at 12:35 PM revealed the substance was paint on the sprinkler head. The DOM stated he was not aware paint could not be on sprinkler heads. During the survey, resident rooms 900 and 301 were also observed to have paint on the sprinkler heads. The findings were revealed to the Administrator upon exit. Reference: NFPA 25 (1998 Edition). 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130	- See Attachment -	

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K 130	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain clothes dryers in an approved manner. This deficient practice affected one (1) of seven (7) smoke compartments, staff, and other occupants of the building. The facility has the capacity for 143 beds with a census of 138 on the day of the survey..... The findings include: During the Life Safety Code tour on 09/09/14 at 12:05 PM with the Director of Maintenance (DOM) a large amount of lint buildup was observed on top of the dryer's lint trap in the lower compartment of the dryer. This may cause the temperature sensors in this area of the dryer not to function correctly. Failure to maintain this area may cause the tumbler to overheat. An interview with the DOM on 09/09/14 at 12:05 PM revealed the lint screen was cleaned daily but not on top around the temperature sensors. The findings were revealed to the Administrator upon exit. Reference: NFPA 101 (2000 Edition). 4.5.7 Maintenance. Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such	K 130		

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K 130	Continued From page 5 device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance.	K 130		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure electrical wiring met National Fire Protection Association Standards (NFPA). This deficient practice affected one (1) of seven (7) smoke compartments, staff, and residents. The facility has the capacity for 143 beds with a census of 138 on the day of the survey. The findings include: During the Life Safety Code survey on 09/09/14 at 11:40 AM with the Director of Maintenance (DOM), an appliance cord to the floor model hairdryer in the Beauty Shop was observed to be missing the ground plug. Cords must be properly maintained to prevent potential electrical hazards. An interview with the DOM on 09/09/14 at 11:40 AM revealed he was not aware the ground plug was missing. On 09/09/14 at 12:40 PM with the DOM, an extension cord was observed to be plugged in and running behind a wall to a TV set in the	K 147	- See Attachment -	

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K 147	<p>Continued From page 6</p> <p>resident Smoke room. The TV must have an approved electrical power source.</p> <p>An interview with the DOM on 09/09/14 at 12:40 PM revealed he was not aware the extension cord was not an approved power source.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>4.5.7 Maintenance. Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance.</p> <p>Reference: NFPA 70 (1999 Edition).</p> <p>400-8. Uses Not Permitted</p> <p>Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces <p>Exception: Flexible cord and cable shall be</p>	K 147		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185166	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2014
NAME OF PROVIDER OR SUPPLIER HARLAN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEDICAL CENTER DRIVE HARLAN, KY 40631	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 7 permitted to be attached to building surfaces in accordance with the provisions of Section 364-B. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code	K 147		

Harlan Health and Rehabilitation Center**Annual Survey September 09-11, 2014****Plan of Correction****K 029**

1. The magnetic hold-open device was removed from the corridor door to the nurse supply room. A door closing device was added to the adjacent housekeeping supply room door. The kick stand hold-open device was removed from the mechanical room door. These doors remain closed when not in use.
2. All doors were inspected to ensure that hazardous area doors are maintained as required. Specifically, each door was inspected to ensure that doors to hazardous areas have a door-closing device but did not have unapproved hold-open devices.
3. An In-service was conducted on September 11th, 2014 with the Director of Maintenance and the Administrator. This in-service was provided by the Corporate Maintenance consultant. The in-service specifically addressed the fact that hazardous area doors cannot be held open unless connected to the fire alarm system and are required to have an automatic door closure.
4. The CQI committee designees will observe all doors during walking rounds throughout the facility weekly for one month and then monthly for one quarter thereafter. Any irregularities will be corrected immediately and reported to the CQI Committee for further follow-up and review.
5. Completion date: October 3, 2014.

Harlan Health and Rehabilitation Center**Annual Survey September 09-11, 2014****Plan of correction****K 062**

1. All sprinklers identified were cleaned or replaced if indicated.
2. All other sprinkler heads were inspected to ensure they are free of corrosion, foreign materials, paint and physical damage.
3. An in-service was conducted on September 11, 2014 with the Administrator and Director of Maintenance regarding maintenance of the sprinkler system. Specifically discussed was the importance of scheduled inspections to ensure sprinklers are free of corrosion, foreign materials, paint and physical damage. This in-service was provided by the Corporate Maintenance Consultant.
4. The CQI designee will inspect all sprinkler heads monthly for 3 months and then quarterly thereafter. Sprinkler heads will be checked to ensure they are free of corrosion, paint or debris and are working properly. Any irregularities will be corrected immediately and reported to the CQI Committee for further follow up and review.
5. Date of Completion: October 10, 2014.

Harlan Health and Rehabilitation Center**Annual Survey September 09-11, 2014****Plan of Correction****K 130**

1. The lint buildup from the top of the dryer's lint trap was immediately removed.
2. All the other dryers were checked and cleaned to ensure they were free of lint buildup.
3. An in-service was conducted on September 9, 2014 with the Director of Maintenance (DOM) regarding the importance of all dryers being free of lint buildup and implementing a schedule with an increase in frequency for lint removal. This in-service was provided by the Corporate Maintenance Consultant.
4. The CQI Committee designee will check the dryers 5 days a week for one month and 3 times a week thereafter. Any irregularities will be addressed immediately and reported to the CQI Committee for further follow-up and review.
5. Completion Date: September 9, 2014.

Harlan Health and Rehabilitation Center**Annual survey September 09-11, 2014****Plan of Correction****K 147**

1. A new ground plug was immediately installed to the floor model hair dryer in the beauty shop. The extension cord that was plugged in and running behind the wall to the TV set in the resident smoke lounge was immediately removed. The TV is currently plugged directly into an approved electrical wall outlet.
2. Walking rounds were performed throughout the facility to ensure no other extension cords were in use. No other extension cords were found including any cords running through holes in the walls, ceilings or floors. All electrical equipment was inspected. No other electrical issues including any missing ground plugs were observed.
3. An in-service was conducted with the Director of Maintenance on September 9, 2014 regarding electrical wiring and equipment in accordance with National Fire Protection Association Standards. Information reviewed included the general maintenance of electrical equipment and prevention of potential electrical hazards. This in-service was provided by the Corporate Maintenance Consultant.
4. The CQI Committee designee will perform walking rounds every week for 1 month and then every month for 3 months to ensure that no unapproved electrical equipment is in use and no potential hazards exist. Any irregularities will be corrected immediately and reported to the CQI Committee for further follow up and review.
5. Completion Date: September 9, 2014.