

10/13/2015 16:11 6065736734

PAGE 03/33

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

 PRINTED: 10/01/2015  
 FORM APPROVED  
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <u>Care</u> B. WING: <u>Enforcement Branch</u>	(X3) DATE SURVEY COMPLETED  C 09/17/2015
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A standard health survey was conducted on 09/15-17/15. Deficient practice was identified with the highest scope and severity at "E" level.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure services were provided to maintain a sanitary and comfortable interior. Observations on 09/16/15 revealed three (3) mobile reclining chairs (Geri-chairs) utilized by residents, one (1) resident fall mat, and one (1) wheelchair bumper guard were noted to be in need of repair.  The findings include:  Review of the facility's policy titled "Protocol for Maintenance Services," (not dated) revealed patient care items in need of repair would be removed from use/resident care areas until it could be repaired or replaced.  Observations during the environmental tour on 09/16/15 at 11:08 AM revealed a mobile reclining	F 253	- See Attachment -	

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

TITLE

(X6) DATE

Maia Newberry, Administrator 10/13/2015

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.

10/13/2015 16:11 6065736734

PAGE 04/33

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

PRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185188	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/17/2015
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 253	<p>Continued From page 1</p> <p>chair located in the West women's shower room in need of repair, scratched and jagged on the left and right armrest, and on the lower front area of the chair. Further observation on 09/16/15 at 11:18 AM revealed a mobile reclining chair located in the West men's shower room in need of repair, scratched and jagged on the right armrest. Additional observation on 09/16/15 at 1:30 PM revealed a mobile reclining chair located in the East women's shower room in need of repair, scratched and jagged on the lower front area of the chair. Further observation on 09/18/15 at 1:51 PM revealed a fall mat located in resident room 10B-1, scratched/torn and in need of repair. Additional observation on 09/16/15 at 1:53 PM outside of resident room 10B in the hallway revealed a wheelchair bumper guard (attached to the wall to protect the wall) in need of repair as the wheelchair bumper guard was loose and disconnected from the wall.</p> <p>Interview with State Registered Nurse Aide (SRNA) #5 on 09/16/15 at 11:15 AM revealed mobile reclining chairs in the shower rooms were utilized for residents.</p> <p>Interview with Registered Nurse (RN) #5 on 09/16/15 at 11:18 AM revealed the Geri-chairs in the West women's shower room were used by residents on the morning of 09/16/15.</p> <p>Interviews with the Maintenance Director on 09/16/15 at 11:08 AM and on 09/18/15 at 3:50 PM revealed he was aware of some concerns with Geri-chairs, fall mats, and wheelchair bumper guards, but when asked about the repairs the Maintenance Director stated, "I just didn't get around to do it." Further interview revealed the Maintenance Director did not document items</p>	F 253			

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

PRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185188	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/17/2015
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 253	Continued From page 2 that were identified to be in need of repair.  Interview with the facility's Administrator on 09/17/15 at 4:09 PM revealed she was not aware of the Geri-chairs, fall mat, and wheelchair bumper guard in need of repair. Further interview revealed staff was required to report defects and equipment not working to Maintenance staff. Further interview with the Administrator revealed Maintenance staff was responsible for repairing and/or replacing Geri-chairs, fall mats, and wheelchair bumper guards.	F 253			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  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.  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).  This REQUIREMENT is not met as evidenced	F 279	- See Attachment -		

10/13/2015 16:11 6065736734

PAGE 07/33

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

PRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  188166	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/17/2016
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279	<p>Continued From page 3</p> <p>by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure a comprehensive plan of care was developed that addressed the care needs related to nail care for one (1) of twenty-four (24) sampled residents (Resident #11). The facility assessed Resident #11 to require limited assistance of one (1) person related to personal hygiene. However, review of Resident #11's comprehensive plan of care revealed personal hygiene related to nail care was not addressed on the plan of care.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Care Plan Policy and Procedure," with a revision date of August 2012, revealed the facility's Care Planning/Interdisciplinary Team was responsible for the development of an individual comprehensive care plan for each resident. Further review of the facility's policy revealed the care plan was based on the resident's comprehensive assessment and was developed by a Care Planning/Interdisciplinary Team.</p> <p>Review of Resident #11's medical record revealed the facility admitted the resident on 08/29/13 with diagnoses that included Dementia, Hypertension, and Coronary Atherosclerosis.</p> <p>Review of an annual Minimum Data Set (MDS) assessment dated 08/05/15 revealed Resident #11 had been assessed by the facility to require the limited assistance of one (1) person for personal hygiene. Review of Resident #11's plan of care dated 08/07/15 revealed no plan of care had been developed to address nail care for</p>	F 279			

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

PRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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  C 09/17/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  HARLAN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEDICAL CENTER DRIVE HARLAN, KY 40831
---	---

(K4) 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
--------------------	--	---------------	---	----------------------

F 279	<p>Continued From page 4 Resident #11.</p> <p>Observation of Resident #11 on 09/15/15 at 3:15 PM with State Registered Nursing Assistant (SRNA) #2 and SRNA #6 revealed the resident's toenails were long and in need of trimming.</p> <p>Interview conducted with Registered Nurse (RN) #3 on 09/17/15 at 5:38 PM revealed she was responsible for developing Resident #11's comprehensive plan of care. The RN stated she should have developed interventions related to nail care for Resident #11.</p> <p>Interview conducted with the Director of Nursing on 09/17/15 at 5:45 PM revealed she attended meetings where residents' comprehensive plans of care were reviewed and discussed. The DON stated Resident #11 should have had interventions developed to address the trimming of the resident's nails.</p>	F 279		
F 282 SS=D	<p>483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to provide services in accordance with the plan of care to maintain grooming and personal hygiene for one (1) of twenty-four (24) sampled residents (Resident #14). Review of the</p>	F 282	- See Attachment -	

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

PRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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  C 09/17/2015
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 5</p> <p>plan of care for Resident #14 revealed interventions to clean and trim toenails on bath days as necessary. Observations on 09/16/15 and during skin assessments on 09/16/15 revealed Resident #14 had long nails that were in need of trimming.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Care Plan Policy and Procedure," with a revision date of August 2012, revealed the facility's Care Planning/Interdisciplinary Team was responsible for the development of an individual comprehensive care plan for each resident. Further review of the facility's policy revealed the care plan was based on the resident's comprehensive assessment and was developed by a Care Planning/Interdisciplinary Team.</p> <p>Review of the facility policy titled "Protocol for Nail Care," undated, revealed nail care would be provided weekly.</p> <p>Review of Resident #14's medical record revealed the facility admitted the resident on 02/19/15 with diagnoses that included Hypertension, Dementia, and Anxiety.</p> <p>Review of a Significant Change Minimum Data Set (MDS) assessment dated 08/05/15 revealed Resident #14 required the total assistance of one (1) person for personal hygiene. Review of Resident #14's plan of care dated 08/08/15 revealed the facility would check nail length, trim, and clean nails on bath day and as necessary. Staff was to report any changes to the nurse.</p> <p>Observation of Resident #14 on 09/15/15 at 3:05</p>	F 282			

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

PRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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  C 09/17/2015
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 6</p> <p>PM revealed the resident's toenails were long and thick on both feet and in need of trimming.</p> <p>Observation of a skin assessment for Resident #14 on 09/16/15 at 1:50 PM with State Registered Nursing Assistant (SRNA) #1 and SRNA #2 revealed the resident's toenails were long and in need of trimming. The SRNAs were not observed to trim the resident's toenails during the skin assessment.</p> <p>Interview conducted with SRNA #2 on 09/18/15 at 4:35 PM revealed that SRNAs were responsible for providing the nail care to Resident #14 on his/her bath day on 09/13/15. The SRNA stated that the SRNAs are required to check and trim a resident's nails on bath days unless they were diabetic and then the nurse was required to trim the resident's nails but she did not clip them on the last bath day.</p> <p>Interview conducted with Registered Nurse (RN) #5 on 09/17/15 at 5:40 PM revealed she was responsible for Resident #14's care on 09/13/15. The RN stated she performed a skin assessment for Resident #14 on 09/13/15. The RN stated she did not check Resident #14's nails and should have as part of the skin assessment. The RN stated she made rounds every two (2) hours to ensure residents were being provided with the care they required;</p> <p>Interview conducted with the Director of Nursing on 09/17/15 at 5:45 PM revealed she made rounds every day to ensure residents were being provided the care they required according to the plan of care. The DON stated she randomly checked residents' nails to ensure they were being trimmed and had not identified any</p>	F 282		

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

PRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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  C 09/17/2015
--	--	--	---

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
--------------------	--	---------------	---	----------------------

F 282	Continued From page 7 concerns. The DON stated resident's nails were required to be checked during the weekly skin assessment by the nurse and during the residents' baths.	F 282		
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure necessary services to maintain grooming and personal hygiene were provided for two (2) of twenty-four (24) sampled residents (Resident #11 and Resident #14). Observations during skin assessments on 09/15/15 revealed Resident #11 and Resident #14 had long nails that were in need of trimming.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Protocol for Nail Care," undated, revealed nail care would be provided weekly.</p> <p>1. Review of Resident #11's medical record revealed the facility admitted the resident on 08/29/13 with diagnoses that included Hypertension, Dementia, and Coronary Atherosclerosis.</p>	F 312	- See Attachment -	

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

PRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105186	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/17/2015
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	<p>Continued From page 8</p> <p>Review of an annual Minimum Data Set (MDS) assessment dated 08/05/15 revealed Resident #11 required the limited assistance of one (1) person for personal hygiene. Review of Resident #11's plan of care dated 08/07/15 revealed the facility had not developed a plan of care to address the trimming of Resident #11's nails.</p> <p>Observation of a skin assessment for Resident #11 on 09/15/15 at 3:15 PM with State Registered Nursing Assistant (SRNA) #2 and SRNA #6 revealed the resident's toenails were long and in need of trimming. The SRNAs were not observed to trim the resident's toenails during the skin assessment.</p> <p>Interview conducted with SRNA #6 on 09/15/15 at 5:20 PM revealed she was responsible for providing the nail care to Resident #11 on his/her bath day on 09/13/15. The SRNA stated she planned to trim Resident #11's toenails, but had gotten busy and forgot to. The SRNA stated she was required to check and trim a resident's nails on bath days unless they were diabetic and then the nurse was required to trim the resident's nails.</p> <p>Interview conducted with Registered Nurse (RN) #5 on 09/17/15 at 5:40 PM revealed she was responsible for Resident #11's care on 09/13/15. The RN stated she performed a skin assessment for Resident #11 on 09/13/15. The RN stated she had not checked Resident #11's nails and should have as part of the skin assessment. The RN stated she made rounds every two (2) hours to ensure residents were being provided with the care they required.</p> <p>2. Review of Resident #14's medical record revealed the facility admitted the resident on</p>	F 312			

10/13/2015 16:11 6065736734

PAGE 15/33

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

PRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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  C 09/17/2015
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X3) COMPLETION DATE	
F 312	<p>Continued From page 8</p> <p>02/19/15 with diagnoses that included Hypertension, Dementia, and Anxiety.</p> <p>Review of a Significant Change Minimum Data Set (MDS) assessment dated 08/05/15 revealed Resident #14 required the total assistance of one (1) person for personal hygiene. Review of Resident #14's plan of care dated 08/08/15 revealed the facility would check nail length, trim, and clean on bath day and as necessary.</p> <p>Observation of Resident on 09/15/15 at 3:05 PM revealed the resident's toenails were long and thick on both feet and in need of trimming.</p> <p>Observation of a skin assessment for Resident #14 on 09/16/15 at 1:50 PM with SRNA #1 and SRNA #2 revealed the resident's toenails were long and in need of trimming. The SRNAs were not observed to trim the resident's toenails during the skin assessment.</p> <p>Interview conducted with SRNA #2 on 09/16/15 at 4:35 PM revealed that she was responsible for providing the nail care to Resident #14 on his/her bath day on 09/13/15, but did not clip the resident's nails on 09/13/15. The SRNA stated that the SRNAs were required to check and trim a resident's nails on bath days unless they were diabetic and then the nurse was required to trim the resident's nails.</p> <p>Interview conducted with Registered Nurse (RN) #5 on 09/17/15 at 5:40 PM revealed she was responsible for Resident #14's care on 09/13/15. The RN stated she performed a skin assessment for Resident #14 on 09/13/15. The RN stated she had not checked Resident #14's nails and should have as part of the skin assessment. The RN</p>	F 312			

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

PRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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  C 09/17/2015
--	--	--	---

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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 312	Continued From page 10 stated she made rounds every two (2) hours to ensure residents were being provided with the care they required.  Interview conducted with the Director of Nursing on 09/17/15 at 5:45 PM revealed she made rounds every day to ensure residents were being provided the care they required. The DON stated she randomly checked residents' nails to ensure they were being trimmed and had not identified any concerns. The DON stated residents' nails were required to be checked during the weekly skin assessment by the nurse and during the residents' baths.	F 312		
F 371 SS-E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of facility policies, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions for fifty-six (56) of one hundred thirty-two (132) residents of the facility who	F 371	- See Attachment -	

10/13/2015 16:11 6065736734

PAGE 18/33

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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  C 09/17/2015
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 11</p> <p>received nutrition from the kitchen. Observations on 09/15/15 and 09/16/15 revealed the kitchen staff was not cleaning the "Robot Coupe Blixer" (a food processor used to puree and grind food) blades according to manufacturer's guidelines and facility policy. Further observations revealed gallons of expired milk were available for use.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Food Storage," undated, revealed that once a product reached the 'use by' date, the product would be disposed of.</p> <p>Review of the facility's policy, "Robot Coupe," undated, revealed when cleaning the food processor staff was to disassemble and clean it immediately after each use. Staff was directed to wash removable parts in clean hot water with detergent, rinse in hot water, sanitize, dry thoroughly, wipe off the stationary base and area surrounding the machine, and then reassemble the machine.</p> <p>Review of the "Operation Manual for Robot Coupe Blixer" revealed "the blade assembly should be taken completely apart and washed after each days use for sanitary reasons."</p> <p>1. Observation on 09/15/15 at 11:15 AM on the initial tour revealed one (1) gallon of fat-free milk with a 'use by' date of 09/14/15 and one (1) gallon of fat-free milk with a 'use by' date of 08/20/15 located in the walk-in cooler and available for use.</p> <p>2. Observations and interviews on 09/16/15 at 4:10 PM revealed that when Cook #1 was asked</p>	F 371		

10/13/2015 16:11 6065736734

PAGE 19/33

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

PRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  188188	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/17/2015
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 12</p> <p>about the Robot Coupe blade assembly, she was unable to tell the surveyor how to properly take the blade assembly apart to properly clean and sanitize it and stated that the blade assembly did not come apart. The Dietary Manager also stated that the blade did not come apart for cleaning. Observations revealed the Maintenance Director took apart the blade assembly using a vise. When the blade assembly was disassembled, observations revealed a thick coating of white, brown, and black food particles on the walls of the center assembly and a brown rust-like coating on the inside center blade assembly.</p> <p>Interview with Cook #1 on 09/17/15 at 1:45 PM revealed that she had never taken the Robot Coupe blade assembly apart to clean it and did not know it came completely apart for cleaning. Cook #1 further stated the outdated milk should have been thrown away.</p> <p>Interview with the Dietary Manager on 09/17/15 at 1:35 PM revealed that the outdated milk should not have been in the walk-in cooler. She stated the milkman usually rotated the milk and he must have missed the outdated milk. She also said that staff should have been taking the Robot Coupe blade assembly apart but they did not know it came apart.</p> <p>Interview with the Registered Dietitian (RD) on 09/17/15 at 11:19 AM revealed that the milkman should have rotated the outdated milk, but it was ultimately the kitchen staff's responsibility and it should not have been in the walk-in cooler. The RD further stated according to the manufacturer's instructions the Robot Coupe Blixer blade assembly should have been taken apart completely at least once a day to be cleaned.</p>	F 371			

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

PRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/17/2015
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456 F 456 SS=E	Continued From page 13 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION  The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and a review of the Kentucky Administrative Regulations, it was determined the facility failed to maintain essential equipment in safe operating condition as evidenced by observation during the environmental tour on 09/16/15, which revealed water temperatures at the sink in three (3) of seventy-four (74) rooms were above 110 degrees Fahrenheit (F). In addition, the facility failed to comply with the maximum hot water temperature of 110 degrees (F) identified in state regulation 902 KAR 20:310, Section 16.(5)(g).  The findings include:  Interview with Maintenance Director on 09/16/15 at 1:25 PM revealed the facility did not have a policy related to water temperatures.  Review of Kentucky Administrative Regulation 902 KAR 20:310, Section 16.(5)(g), revealed the plumbing fixtures which required hot water and which were intended for patient use shall be supplied with water which was controlled to provide a maximum water temperature of 110 degrees (F) at the fixture.  Review of the facility's Weekly Hot Water	F 456 F 456	- See Attachment -	

10/13/2015 16:11 6065736734

PAGE 23/33

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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  C 09/17/2015
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 456	Continued From page 14 Temperature Log Sheet for July, August, and September 2015 revealed on 09/17/15 the facility recorded the hot water temperatures to be within range according to the Kentucky Administrative Regulation.  Observations conducted on 09/16/15 revealed hot water temperatures at the sink in resident rooms were as follows: resident room 108 was 116 degrees (F) at 1:51 PM, resident room 109 was 116 degrees (F) at 1:53 PM, and resident room 103 was 114 degrees (F) at 1:55 PM.  Interview on 09/16/15 at 1:25 PM with the Maintenance Director, revealed he thought the range for the hot water in residents' rooms was between 101-103 degrees (F). Further interview revealed, "No one has told me what the range is supposed to be." Additional interview with the Maintenance Director on 09/17/15 at 3:50 PM revealed he performed weekly hot water checks, and had not identified any concerns with the water temperatures. Further interview revealed the mixing valve gauge became stuck, causing the spike in the water temperatures.  Interview with the Administrator on 09/17/15 at 4:09 PM revealed the Maintenance Director was responsible for checking the water temperatures in residents' rooms weekly, and if there were any concerns, he addressed them immediately. Further interview revealed she was unaware of any concerns with the water temperatures.	F 456			
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS  The facility must equip corridors with firmly secured handrails on each side.	F 468	- See Attachment -		

10/13/2015 16:11 6065736734

PAGE 24/33

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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  C 09/17/2015
NAME OF PROVIDER OR SUPPLIER  HARLAN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 290 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 468	Continued From page 15  This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to ensure handrails were securely fastened to the wall. Observations revealed two (2) of twenty (20) handrails located inside the facility and two (2) of eight (8) handrails and fifteen (15) spindles on the front porch were loose and not securely fastened.  The findings include:  Interview with the Administrator on 09/17/15 at 4:08 PM revealed the facility does not have a policy regarding handrails.  Observation on 09/16/15 at 1:18 PM on the "Beach Lane" and across from the janitor's closet revealed the handrail was not firmly attached to the wall and moved when it was handled. Further observation at 2:50 PM revealed the handrail next to the activities room was not firmly attached to the wall and moved when it was handled. In addition, on 09/16/15 at 3:27 PM, Resident #18 requested that surveyors check the banisters/railings on the front porch. Observations on the front porch at 3:29 PM revealed there were two (2) of eight (8) handrails and fifteen (15) spindles that were loose and in need of repair. Observations revealed five (5) residents were outside and sitting within the handrails (Resident #2, Resident #15, and Residents A, B, and C).  Interview with Resident C on 09/16/15 at 3:30 PM revealed the resident was concerned that the handrails on the porch would not hold him/her.	F 468			

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

PRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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  C 09/17/2015
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 488	Continued From page 18  Interview with the Maintenance Director on 09/17/15 at 3:50 PM revealed he conducted weekly checks on the handrails and had not identified any problems. Further interview revealed if he did find a loose handrail, he fixed it immediately.  Interview with the Administrator on 09/17/15 at 4:09 PM revealed the Administrator was not aware there were loose handrails inside and outside the facility.	F 488			
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS  The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.  This REQUIREMENT is not met as evidenced by: Based on interview, facility in-service training, and facility policy review it was determined the facility failed to ensure one (1) of three (3) staff members interviewed were effectively trained in emergency preparedness related to tornados. Interview with Licensed Practical Nurse (LPN) #1 on 09/16/15 revealed the LPN did not know the difference between a tornado watch and a tornado warning and was unable to explain facility procedures related to the emergency situations.  The findings include:	F 518	- See Attachment -		

10/13/2015 16:11 6065736734

PAGE 27/33

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

PRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185108	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/17/2015
NAME OF PROVIDER OR SUPPLIER  HARLAN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 518	<p>Continued From page 17</p> <p>Review of the facility's policy titled "Tornado Warning," (undated) revealed the policy instructed staff on actions to take during a tornado warning. Staff was directed to try to get all patients into a central hall and away from windows. The policy stated bedfast patients could be moved away from windows, placed against the interior wall, and cubicle curtains pulled around the resident's bed. The policy further stated for staff to close all doors to vacant patient rooms and see that each patient has a blanket to cover himself or herself.</p> <p>Review of the facility's policy, "Recommended In-services" revealed Fire/Disaster Preparedness/Use of Fire Extinguisher was to be in-serviced to staff quarterly.</p> <p>Interview with LPN #1 on 09/18/15 at 2:31 PM revealed during a tornado warning she was to get residents to safety while overseeing the aides and helping out. Further interview with LPN #1 revealed she did not know the difference between a tornado watch and a tornado warning and was unable to verbalize facility procedures to assure resident safety during the events. Additional interview revealed she was trained quarterly on emergency preparedness and disasters.</p> <p>Review of the facility's in-services regarding tornados revealed in-services were conducted on 03/20/15, 06/12/15, and 08/21/15. Further review of the facility's in-services revealed LPN #1 only attended the 06/12/15 in-service.</p> <p>Interview with the Director of Nursing (DON) on 09/17/15 at 3:46 PM revealed she was responsible for in-services related to tornados. Further interview revealed staff was in-serviced</p>	F 518			

10/13/2015 16:11 6065736734

PAGE 28/33

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

PRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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  C 09/17/2015
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 518	Continued From page 18 regarding tornadoes upon hire and quarterly, and tornado drills were conducted. The DON stated she had not identified any concerns with staff not knowing what to do in a tornado event.  Interview with the Administrator on 09/17/15, at 4:09 PM, revealed the facility had in-services, drills in the springtime, and quizzes at random times that involved tornadoes and had not identified any concerns.	F 518			

**Harlan Health & Rehabilitation Center  
Plan of Correction  
Annual Survey— September 15-17, 2015**

**F 253**

1. All environmental and/or maintenance issues identified during survey have been addressed and corrected. The three mobile reclining chairs (Gerl-chairs) identified were removed from resident use. One chair was repaired and the other two were replaced. The fall mat identified in room 108-1 has been replaced with a new one. The wheelchair bumper guard was repaired. It was stabilized and tightened by adding a corner piece to the left side.
2. A thorough environmental round was performed by the Administrator, Maintenance Director and Housekeeping Supervisor to identify any other problems and to ensure all environmental issues have been addressed and corrected. All resident areas are safe, functional, sanitary and comfortable.
3. An in-service was conducted with the Director of Maintenance, (DOM) on 09/18/15 by the Administrator. The in-service included ensuring that any equipment that was reported to be in need of repair had been removed from resident use and that he documents the date issues were identified to ensure repairs are made timely. In-services were conducted with nursing and housekeeping staff on 09/18/15 through 10/09/15 regarding reporting environmental issues/damaged equipment as soon as these problems are identified using the CQI referral form and removing equipment in need of repair from resident use. The CQI referral form is to be given to the DOM and a copy to the Administrator.
4. Thorough environmental rounds will be conducted once a week for one month, then once a month for one quarter by a CQI Committee member designee. Any irregularities will be corrected immediately and reported to the CQI committee for further review.
5. Completion Date: 10/10/2015

**Harlan Health & Rehabilitation**  
**Plan of Correction**  
**Annual Survey— September 15-17, 2015**

**F 279**

1. Resident #11's toenails have been trimmed. Her comprehensive plan of care has been updated to address nail care.
2. The plan of care for each resident was reviewed to ensure that nail care was being addressed on each plan as appropriate. Additionally, a thorough review of all residents' toenails was completed by administrative nursing staff to ensure that nail care services were being done in accordance with their plan of care.
3. In-services was conducted with the clinical and MDS Coordinators on 09/17/15 by the Administrator and Director of Nursing, (DON) regarding the importance of ensuring that the plan of care addresses all residents' needs and includes an individualized plan for nail care. In-services were conducted with all nursing staff by the DON and Administrative Nursing on 09/18/15 through 09/25/15 regarding nail care being provided weekly in accordance with the skin assessment schedule and additionally as needed.
4. A CQI Committee designee will conduct random audits of residents' plan of care to ensure that each resident's nail care needs are being addressed. The residents whose care plans are reviewed will be observed to ensure that nail care was provided as indicated. These audits will be completed on six residents per unit each week for one month then monthly for one quarter. Any irregularities will be reported to the CQI committee for review.
5. Completion Date: 09/26/2015

**Harlan Health & Rehabilitation Center  
Plan of Correction  
Annual Survey— September 15-17, 2015**

**F 282**

- 1. Resident # 14's toenails have been trimmed to a short but comfortable length. She is receiving appropriate nail care and services by nursing staff in accordance to the plan of care.**
- 2. A thorough review of all resident's toenails was completed by administrative nursing staff to ensure that nail care services were being provided in accordance with their plan of care.**
- 3. In-services were conducted with all nursing staff by the Director of Nursing and Administrative Nursing staff on 09/18/15 through 09/25/15 regarding routine nail care. A focus of the in-service was on the importance of following the facility protocol for providing weekly nail care to residents.**
- 4. A CQI committee designee will conduct random observations to ensure that nail care is being provided in accordance with the plan of care. These observations will be completed on six residents per unit every week for one month then monthly for one quarter. Any irregularities will be reported to the CQI committee for review.**
- 5. Completion Date: 09/26/2015**

**Harlan Health & Rehabilitation Center  
Plan of Correction  
Annual Survey— September 15-17, 2015**

**F 312**

1. Residents #11 & #14 are receiving appropriate nail care services by nursing staff in accordance to the plan of care. Both residents' toenails have been trimmed to a short but comfortable length.
2. A thorough review of all resident's toenails was completed by administrative nursing staff to ensure that services were being provided to maintain good personal hygiene and grooming, in accordance with their plan of care.
3. In-services were conducted with all nursing staff by the Director of Nursing and Administrative Nursing Staff on 09/18/15 through 09/25/15 regarding good personal hygiene and grooming with nail care being provided weekly in accordance with the skin assessment schedule and additionally as needed.
4. A CQI committee designee will conduct random observations to ensure that nail care is being provided in accordance with the plan of care. These observations will be completed on six residents per unit every week for one month then monthly for one quarter. Any irregularities will be reported to the CQI committee for review.
5. Completion Date: 09/26/2015

**Harlan Health & Rehabilitation Center  
Plan of Correction  
Annual Survey— September 15-17, 2015**

**F 371**

1. The Robot Coupe Blixer has been disassembled and cleaned. A special tool used in disassembling the appliance was ordered and arrived on 09/18/15. The 2 gallons of expired milk were discarded immediately.
2. All appliances in the kitchen were observed to ensure they are clean and sanitary as well as being disassembled as needed for cleaning per the manufacturer's recommendations. A thorough assessment was performed on all food and beverages to ensure all items were fresh and properly stored.
3. In-services were conducted with the dietary department by the Registered Dietitian and Dietary Manager on 09/17/15 regarding disassembling/cleaning the Robot Coupe Blixer and observing for and discarding food or beverages that are out of date. Staff was instructed to clean the Robot Coupe Blixer at the end of each day's use. It has been added to the cook's daily assignment to check the milk for freshness and specifically on delivery days to check after delivery has been made.
4. The CQI committee designee will conduct random checks in the kitchen to ensure that all sanitary requirements are being met and that any food items available for use are fresh and dated accordingly. These audits will be conducted weekly for one month, then monthly for one quarter. Any irregularities will be corrected immediately and reported to the CQI committee for further review.
5. Completion Date: 09/19/2015

**Harlan Health & Rehabilitation Center  
Plan of Correction  
Annual Survey—September 15-17, 2015**

**F 456**

1. The water temperature elevation was addressed and corrected on 09/16/15. Residents' rooms 103, 108 & 109 water temperatures are between the acceptable ranges of 100-110 degrees.
2. Water temperatures were monitored daily for one week (from 09/17 thorough 09/25) on both units with no further problems identified.
3. The Director of Maintenance, (DOM) was in-serviced by the Administrator on 09/18/15 on the regulation regarding water temperatures and the importance of the temperature being maintained between 100 to 110 degrees. Nursing staff were in-serviced by the Director of Nursing, (DON) to notify the DON, Administrator or the DOM if there is a concern regarding the water being out of range.
4. Water temperatures will be checked for resident use by a CQI designee three times a week for one month and then weekly thereafter. Any irregularities will be addressed immediately and reported to the CQI committee for review.
5. Completion Date: 09/26/2015

**Harlan Health & Rehabilitation Center  
Plan of Correction  
Annual Survey---September 15-17, 2015**

**F 468**

1. The handrails on "Beach Lane" across from the janitor's closet and next to the Activities room have been tightened and are firmly secured. For added security a 4ft 2 x 4 was installed in parallel position behind the wall of the activities room and the handrail was anchored to it. The handrails and spindles on the front porch were tightened. New bolts & rails were installed and the 15 spindles were anchored down utilizing self tapping screws.
2. All handrails in the facility were checked to ensure there were no other loose handrails. No further problems were identified.
3. The Director of Maintenance was in-serviced on September 18, 2015 by the Administrator to conduct daily walking rounds throughout the facility twice weekly to observe for loose handrails and if found, to repair immediately. All staff were in-serviced on 09/25/15 through 10/09/15 regarding reporting loose handrails utilizing the CQI referral form for maintenance repair.
4. The CQI committee member designee will observe for loose handrails weekly for one month, monthly for one quarter and then quarterly for 6 months. Any irregularities will be corrected immediately and reported to the CQI committee for further review.
5. Completion Date: 10/10/2015

**Harlan Health & Rehabilitation Center  
Plan of Correction  
Annual Survey-- September 15-17, 2015**

**F 518**

1. LPN #1 was in-serviced by the administrator and Director of Nursing on 09/21/15 regarding the difference between a tornado watch and a warning. She is currently able to verbalize facility procedures to ensure resident safety in the event of a disaster/emergency.
2. Interviews were conducted with other nursing staff regarding disaster/emergency preparedness with no further issues identified.
3. All staff were in-serviced by the Administrator, Director of Nursing, Housekeeping Supervisor & Dietary Manager on 09/25/15 through 10/09/15 regarding disaster and emergency preparedness with specific focus on tornado watches and warnings.
4. Twelve staff (six from each unit), will be randomly interviewed by a CQI committee designee every week for one month, then monthly for one quarter to verify the staff have the necessary knowledge regarding facility policy and procedures to ensure resident safety in the event of a disaster. In addition, staff drills will be conducted every month for 3 months and then quarterly thereafter. Any identified concerns will be submitted to the CQI committee for review.
5. Completion Date: 10/10/15

10/13/2015 16:11 6065736734



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

PRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185166	(X2) MULTIPLE CONSTRUCTION Branch A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  09/16/2015
--	--	---	--

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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  BUILDING: 01  PLAN APPROVAL: 1978  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One story, Type 111 (000)  SMOKE COMPARTMENTS: 7  FIRE ALARM: Complete automatic fire alarm system.  SPRINKLER SYSTEM: Complete automatic (wet & dry) sprinkler system.  GENERATOR: Type II diesel generator.  A life safety code survey was initiated and concluded on 09/16/15. 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.  Deficiencies were cited with the highest deficiency identified at "D" level.	K 000		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard	K 056	- See Attachment -	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Eric Hensley, Administrator TITLE \_\_\_\_\_ (X6) DATE 10/13/2015

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.

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

PRINTED: 10/01/2015  
FORM APPROVED  
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  09/18/2015	
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	<p>Continued From page 1</p> <p>for the installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure that curtains were maintained so as to not obstruct the sprinkler spray pattern in case of fire. This deficient practice affected two (2) of seven (7) smoke compartments, staff, and approximately twenty-four (24) residents. The facility has the capacity for 143 beds with a census of 141 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 09/16/15 at 1:45 PM with the Director of Maintenance (DOM), shower curtains located in the West men's shower room were observed to be above the 18-inch limit of the sprinkler head. This condition could disrupt the sprinkler water pattern in a fire situation.</p> <p>An interview with the DOM on 09/18/15 at 1:45 PM revealed that another staff member was supposed to order the appropriate shower curtains for the shower rooms.</p>	K 056		

10/13/2015 16:11 5065736734

PAGE 32/33

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

PRINTED: 10/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185186	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  09/16/2015
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 2  During the survey, three other shower rooms were observed to have shower curtains that could disrupt the flow of water in a fire situation.  The findings were revealed to the Administrator upon exit.  Reference: NFPA 13 (1999 Edition).  5-6.5.3° Obstructions that Prevent Sprinkler Discharge from Reaching the Hazard. Continuous or noncontinuous obstructions that interrupt the water discharge in a horizontal plane more than 18 in. (457 mm) below the sprinkler deflector in a manner to limit the distribution from reaching the protected hazard shall comply with this section.	K 056		

**Harlan Health & Rehabilitation Center  
Plan of Correction  
Annual Survey—September 15-17, 2015**

**K 056**

- 1. New shower curtains were ordered for all shower rooms to meet the LSC regulation of being 18 inches from the sprinkler head.**
- 2. A thorough tour was conducted by the Administrator, Director of Maintenance and Housekeeping Supervisor to ensure no other areas of concern existed. No further problems were identified.**
- 3. An in-service was conducted with the Director of Maintenance and the Housekeeping Supervisor on 09/18/2015 by the Administrator regarding the importance of ensuring any/all items are 18 inches or greater from the sprinkler heads.**
- 4. Thorough rounds will be conducted by a CQI designee once a week for one month, once a month for one quarter then quarterly thereafter. Any irregularities will be corrected immediately and reported to the CQI committee for further review.**
- 5. Completion Date: 10/09/2015**