

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

PRINTED: 06/30/2010  
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  06/16/2010
NAME OF PROVIDER OR SUPPLIER  HARLAN NURSING HOME			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 June 14-16, 2010. Deficient practice was identified with the highest scope and severity at an "E" level.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined the facility failed to provide services in accordance with professional standards for one (1) of twenty-four (24) sampled residents. Resident #17 was observed to receive oxygen via nasal cannula at 2.5 liters per minute (LPM) and 3.0 LPM. However resident #17's physician had ordered the oxygen to be administered at 2 LPM.  The findings include:  Review of the medical record for resident #17 revealed the following diagnoses: End Stage Renal Disease (ESRD), Chronic Hemodialysis, Chronic Atrial Fibrillation, Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus (DM) 2, Hypertension, Osteoarthritis, Low Back Pain, Anxiety, Depression, Chronic Pain, Coronary Artery Disease, Congestive Heart Failure, General Weakness, and Hyperlipidemia. The physician's order for resident #17 dated June 1, 2010, revealed an order for oxygen to be administered to this resident at 2 LPM via nasal cannula.	F 281		

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Basil Pace* TITLE *Administrator* (X6) DATE *7/9/10*

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 281	Continued From page 1  Observation of resident #17 on June 15, 2010, at 5:45 p.m., revealed the resident receiving oxygen per nasal cannula with the O2 concentrator setting at 3 LPM. Additional observation of resident #17 on June 16, 2010, at 8:50 a.m., revealed the oxygen concentrator was set at 2.5 LPM.  An interview conducted on June 16, 2010, at 9:15 a.m., with the West Wing Licensed Practical Nurse (LPN) revealed the LPN was responsible to monitor the oxygen concentrator settings, which was usually done during rounds. The LPN stated the LPN had not checked resident #17's oxygen concentrator setting on the morning of June 16, 2010. An additional interview conducted on June 16, 2010, at 11:25 a.m., with the West Wing LPN revealed the LPN had never witnessed resident #17 adjust the oxygen concentrator.  An interview conducted on June 16, 2010, at 11:30 a.m., with a West Wing Certified Nurse Assistant (CNA) revealed the CNA had never observed resident #17 adjust the oxygen setting on the concentrator.	F 281		
F 371 SS=D	483.35(i) 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	F 371		

*Eva L. Hughes*

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F 371	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store food in a sanitary manner. The walk-in freezer was observed to have a large amount of ice accumulation hanging from the fan on the right. In addition, two (2) areas on the floor of the walk-in freezer were observed to have a buildup of ice.</p> <p>The findings include:</p> <p>A sanitation tour of the kitchen was conducted at 9:55 a.m. on June 16, 2010. Observation during the tour revealed the walk-in freezer had a large amount (approximately 12 inches) of ice accumulation hanging from the right side of the fan area of the freezer. In addition, two more areas of accumulated ice were observed on the floor of the walk-in freezer.</p> <p>An interview was conducted with the Dietary Manager (DM) at 10:00 a.m. on June 16, 2010. The DM had not noticed the ice accumulation prior to the surveyor bringing this to the DM's attention. According to the DM, the employee that put up stock was a newer employee and did not know to report the ice buildup.</p>	F 371	
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically</p>	F 431	

*Wendy Hughes*

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F 431	<p>Continued From page 3 reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure medication room temperatures and refrigerators utilized to store medications were monitored consistently for appropriate temperature levels. Observations on June 14, 2010, revealed the temperature in the West Wing medication room to be eighty-two (82) degrees Fahrenheit at 5:45 p.m. Observation of the West Wing medication room refrigerator on June 16, 2010, at 10:20 a.m., revealed there was no</p>	F 431		

*W. L. Hughes*

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F 431	<p>Continued From page 4</p> <p>thermometer inside the medication refrigerator. Observations of the East Wing medication room at 6:00 p.m. on June 14, 2010, revealed there was no thermometer in the East Wing medication room to monitor the temperature.</p> <p>The findings include:</p> <p>Observations in the West Wing medication room on June 14, 2010, at 5:45 p.m., revealed the medication room temperature to be 82 degrees Fahrenheit. Stored in the West Wing medication room at this time were the following:</p> <ol style="list-style-type: none"> <li>1. Eleven vials of Zosyn with storage requirements of 68 to 77 degrees Fahrenheit.</li> <li>2. Three vials of Ceftriaxone required to be stored at a temperature not to exceed 77 degrees Fahrenheit.</li> <li>3. Two vials of Cefepime with storage requirements of 68 to 77 degrees Fahrenheit.</li> <li>4. Eight vials of Merrem with storage requirements of 59 to 77 degrees Fahrenheit; and</li> <li>5. Two vials of Invanz required to be stored at a temperature not to exceed 77 degrees Fahrenheit.</li> </ol> <p>An interview with the Registered Nurse (RN) on June 14, 2010, at 5:45 p.m., revealed the facility's procedure required the 11:00 p.m. to 7:00 a.m. shift staff to check the medication refrigerator and medication room temperatures. The RN was unable to locate a thermometer in the medication refrigerator for staff to utilize when monitoring the temperature inside the refrigerator.</p> <p>An interview with the Regional Quality Assurance Nurse conducted at 6:00 p.m. on June 14, 2010, revealed that although the staff was required to</p>	F 431			

*Eva D. Hefner*

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F 431	Continued From page 5 monitor the medication room/refrigerator temperatures, the staff was unable to locate any temperature logs to provide documentation that staff had monitored the temperatures.  An Interview with the Facility Administrator on June 16, 2010, at 5:05 p.m., revealed the Medication Room Temperature Log had been located. The review of the temperature log revealed temperatures of the medication room for June 11, 12, and 13, 2010, were noted to be 80 degrees Fahrenheit, 80 degrees Fahrenheit, and 82 degrees Fahrenheit respectively. The Administrator was unaware the temperatures had been out of the acceptable range.  Observations in the East Wing medication room on June 14, 2010, at 6:00 p.m., revealed there was no thermometer in place to monitor the temperature of the medication room.	F 431	
F 485 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.  The findings include:  1. Observation of the facility during the	F 465	

*Coral Hughes*

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F 465	<p>Continued From page 6</p> <p>environmental tour on June 14-16, 2010, revealed the following items were in need of maintenance/repair:</p> <ul style="list-style-type: none"> <li>-The emergency call light cover was loose in the bathroom in resident room 302.</li> <li>-A floor drain covering was protruding higher than the floor tile in the hallway near resident room 1008.</li> <li>-The smoke detector in resident room 806 produced an intermittent chirping sound.</li> <li>-The assistive bars at the commode in the men's and women's shower rooms on the West Wing were loose and not tightly secured.</li> <li>-An elongated hole was noted in the wall at the baseboard in resident room 907.</li> <li>-Areas of the ceiling were peeling in resident room 303.</li> <li>-The trim was loose on the bottom of the entrance door of resident room 302.</li> </ul> <p>An interview was conducted on June 16, 2010, at 11:00 a.m., with the Maintenance Supervisor (MS). The MS reported performing daily checks of assigned resident rooms to observe for any items in need of repair. The MS stated any areas reported by facility staff or observed by the maintenance staff were immediately addressed with appropriate action taken. However, the MS stated the areas observed by the surveyor had not been reported by the staff and the MS had been unaware the areas were in need of repair/maintenance.</p> <p>2. Observations on June 16, 2010, at 10:20 a.m., of the medication carts utilized on both the East and West wings revealed the carts to be heavily soiled and dusty.</p>	F 465		

*Wanda Hughes BSN*

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F 465	Continued From page 7 An interview with the Registered Nurse (RN) at 10:20 a.m. on June 16, 2010, revealed the medication aides were required to clean the medication carts weekly and as needed. The RN further stated the Unit Supervisor was responsible to monitor the cleanliness of the medication carts.  An interview with the Unit Supervisor (US) at 10:30 a.m. on June 16, 2010, revealed the US was aware of the responsibility to monitor the cleanliness of the medication carts; however, the US had not checked the cleanliness of the carts during the week of the survey.	F 465		
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM  The facility must maintain an effective pest control program so that the facility is free of pests and rodents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain an effective pest control program to ensure the facility was free of pests. Flies and spiders were observed throughout the facility during the survey conducted on June 14-16, 2010. In addition, flies were observed on resident #20's bed linens and clothing throughout the survey.  1. Observations of resident #20 throughout the survey conducted on June 14 - 16, 2010, revealed flies in the resident's room. Flies were observed on the resident's body, the resident's gown, and the bed sheet covering the resident.	F 469		

*Ewa J. Hughes RNS*

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F 469	<p>Continued From page 8</p> <p>Observation of resident #20 at 10:50 a.m. on June 14, 2010, at 4:43 p.m. and 5:25 p.m. on June 15, 2010, and at 9:15 a.m. and 11:00 a.m. on June 16, 2010, revealed flies remained on the resident and the resident's clothing/bed linens.</p> <p>Interview with resident #20 on June 16, 2010, at 5:15 p.m., revealed the flies did not bother the resident too much because the resident "slapped them off." Interview at 9:15 a.m. on June 16, 2010, with two direct care staff members caring for resident #20 revealed the staff had not observed flies on the resident. The staff member responsible for the care of resident #20 stated this was the first day for the staff member to care for resident #20.</p> <p>2. Observation on June 14, 2010, at 5:10 p.m., revealed a black spider in the back right corner (by the ceiling) of the 900 hallway.</p> <p>3. Observation on June 14, 2010, at 4:45 p.m., revealed a brown spider on the wall of the 1000 hallway.</p> <p>4. Observation on June 14, 2010, at 5:00 p.m., revealed a black spider in the back right upper corner (by the ceiling) of the 1000 hallway.</p> <p>Interview on June 16, 2010, at 11:05 a.m., with the Maintenance Supervisor (MS) revealed the contracted pest control company sprayed monthly for insects.</p> <p>An interview with the Administrator on June 16, 2010, at 11:05 a.m., revealed the Administrator was aware of the flies in the facility and stated flies were difficult to control during the summer months.</p>	F 469		

*Erica E. Hughes R.N. DA*

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F 469	Continued From page 9  A review of the pest control contract revealed the pest control company would provide the facility with a preventive pest treatment on a monthly basis. Review of the last pest control company work order dated May 31, 2010, revealed the pest control company provided treatment for spiders. However, there was no treatment for flies provided by the pest control company.	F 459		

*Eva M. Hughes R. D.D.*

Harlan Nursing Home  
Annual Survey—June 14-16, 2010  
Plan of Correction

F281

- 1) Resident #17 was assessed by Administrative Nursing Staff on 6/16/10 and the oxygen liter flow was set according to the Physician Order.
- 2) All residents on oxygen therapy were assessed by Nursing Staff on 6/16/10 to ensure that the liter flow they were receiving matched the Physician's order.
- 3) An in-service was conducted with the nurses by the Director of Nursing and Nursing Administrative Staff beginning 6/16/10 regarding residents receiving oxygen therapy. All residents will be assessed at the beginning of each shift and as needed by the Charge Nurse to ensure that the oxygen liter flow is set to the appropriate settings per the Physician's order. If at any time, a resident is observed to be changing their liter flow themselves, the staff member observing the behavior will notify the Charge Nurse immediately so he/she can provide education to the resident.
- 4) The CQI Committee will audit residents to make sure the liter flow matches the Physician Orders. Audit will be conducted by direct observation and will consist of 5 audits per week for 1 month, 5 audits per month for one quarter, and then 5 audits per quarter thereafter. Any identified irregularities will be corrected immediately and reported to the CQI Committee for further action.
- 5) Completion Date: 7/9/10

Harlan Nursing Home, Inc.  
Annual Survey—June 14-16, 2010  
Plan of Correction

F 371

1. The ice build up was immediately removed and the maintenance director was notified to assess the problem and determine the cause. He stated the door was defective and was not providing a secure seal. He was aware of this problem and was in the process of getting estimates for a new door.
2. A new door has been ordered and will be installed immediately upon arrival. Until the new door can be installed, dietary staff will check the freezer every shift for ice build up and remove when necessary.
3. Dietary staff was in-serviced on 6/16/10 by the dietary manager on monitoring the freezer for ice build up and reporting any problems not only with the freezer but any problem in general concerning dietary to her immediately.
4. The Dietary manager will check the freezer for further problems 3 times a week until the new door has been installed and once every week for a month thereafter to ensure the new door has corrected the problem and no further problems exist. Her observations will be discussed in the weekly CQI meetings and any irregularities will be addressed and corrected immediately.
5. Date of Completion: 7/9/10

Harlan Nursing Home  
Annual Survey—June 14-16, 2010  
Plan of Correction

F431

- 1) The temperature in the West Wing medication room was adjusted by Maintenance staff on 6/14/10 to ensure the temperature was within the acceptable parameters. All medications that were affected were discarded and new medications were obtained from Pharmacy Services. Temperature logs were initiated and posted in both East and West Wing medication rooms and include acceptable temperature ranges so that Nursing Staff will know at a glance if a temperature meets the requirement. The thermometer in the West Wing medication room refrigerator was replaced on 6/14/2010.
- 2) The medication rooms on East and West Wings have thermometers in the refrigerators and logs to document the appropriate temperatures. The medication rooms on East and West Wings have thermometers in the room and logs to document the appropriate temperatures.
- 3) An in-service was conducted by the Director of Nursing and Nursing Administrative Staff beginning on 6/14/10 for the Nursing Department regarding the appropriate temperatures for the medication rooms and the refrigerators therein. Nursing staff are to document the temperatures on the logs provided each day and report any temperature outside the acceptable parameters to the Nursing Supervisors or the Director of Nursing immediately so that the Maintenance Supervisor can make the appropriate adjustments.
- 4) The CQI Committee will audit the East and West Wing medication rooms and refrigerators to ensure that temperature logs are being maintained and temperatures are within the established parameters. Six temperatures per week will be audited (3 on each unit) for one month, then 6 temperatures per month for 3 months, then 6 temperatures per quarter thereafter.
- 5) Completion Date: 7/9/10

Harlan Nursing Home, Inc.  
Annual Survey—June 14-16, 2010  
Plan of Correction

F 465

1. All environmental issues identified during the survey have been addressed and corrected.
  - a) The emergency call light cover being loose was corrected immediately by the maintenance supervisor (MS). He added a new bolt to secure it.
  - b) The floor around the floor drain cover had been leveled out. We used a product called floor leveler and the tile around the drain were replaced with new tile.
  - c) The smoke detector in room 806 was replaced with a new one.
  - d) We have ordered new bars for the commodes on the men and women's shower rooms on the West wing. We ordered wall to floor "L" shape bars. They are stainless steel and anchor to the wall and floor for added security. Once they arrive they will be installed immediately by the MS.
  - e) The elongated hole observed in room 907 has been repaired. The MS sealed it up using plaster and the area was repainted.
  - f) The areas of ceiling that were observed to be peeling in room 302 has been sanded down and repainted. No further peeling has been observed.
  - g) The trim that was observed to be loose on the bottom of the entrance door of room 302 has been repaired using glue and a new screw plate.
2. A thorough environmental round was made by the administrator, maintenance supervisor and housekeeping supervisor to identify any other problems and to ensure all environmental issues had been addressed and corrected. All resident areas are safe, functional and sanitary.
3. All staff was in-serviced on 7/9/10 by the administrator, administrative nursing staff, dietary manager, and housekeeping supervisor on the importance of maintaining a safe, functional and sanitary environment. The in-service specifically addressed reporting items in need of repair/replacement to the maintenance department utilizing the CQI Referral Form. Additionally staff were reminded to remove any item or equipment in need of repair from resident use. The in-service also included review of the Preventative Maintenance Log Sheet with the Maintenance Department to ensure equipment, rooms, tile, lights, chairs, smoke detectors etc. are periodically checked for proper functioning and pose no danger to residents.
4. Thorough rounds in every room will be conducted once a week for one month, then once a month for one quarter by the maintenance and housekeeping supervisors. Any problems will be reported to the CQI committee and addressed immediately.
5. Completion Date: 7/9/10

Harlan Nursing Home  
Annual Survey—June 14-16, 2010  
Plan of Correction

F 469

1. Resident #20's room has been made as free of flies as is possible. A bug light was placed in the hallway, outside of resident #20's room.
2. All areas of the facilities have been made free of flies and spiders as is possible.
3. Our pest control provider was contacted and they came out to the facility on June 22<sup>nd</sup>. They treated for spiders and additional bug lights were ordered to prevent/control the fly population. In addition, nursing and housekeeping staff were instructed on June 16<sup>th</sup> and again on July 9<sup>th</sup> by the administrator and housekeeping supervisor to attempt to eliminate every fly and/or spider that is observed.
4. The Housekeeping supervisor will conduct walking rounds weekly for one month and then monthly thereafter to ensure the facility has been made as free of flies and spiders as is possible. Any irregularities will be reported to the CQI committee for further follow-up and review.
5. Completion Date: 7/9/10

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

PRINTED: 01/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185166</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>HARLAN HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 MEDICAL CENTER DRIVE HARLAN, KY 40831</b>		
(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	<p><b>INITIAL COMMENTS</b></p> <p>A life safety code survey was initiated and concluded on June 15, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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