STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185166	A. BUILDING _____ B. WING _____	**06/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARLAN HEALTH AND REHABILITATION CENTER	**200 MEDICAL CENTER DRIVE HARLAN, KY 40831**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of Centers for Disease Control and Prevention (CDC) guidelines, and review of the facility's policy, it was determined the facility failed to properly prevent and/or contain COVID-19 for one (1) of five (5) sampled residents (Resident #1). Resident #1 was recently admitted to the facility after being hospitalized and was residing on the facility's COVID-19 Unit. Observation on 06/03/2020 at 9:15 AM, revealed Resident #1 was observed on an ambulance stretcher being transferred from the facility's COVID-19 care unit to the [MEDICAL TREATMENT] clinic. The ambulance crew parked the stretcher with Resident #1 at the Rosewood Place nursing station to talk to the nursing staff. Resident #1 was not observed to have on a face mask. Prior to the ambulance service leaving from the nurses' station Registered Nurse (RN) #1 placed a face mask on the resident. The findings include: Review of the facility's policy titled, Protocol: COVID-19, with a revision date of 04/01/2020, revealed all residents would be monitored daily for symptoms of COVID-19. Monitoring would include daily oxygen saturation and lung sounds. The policy also revealed that the CDC guidelines for identifying, monitoring, and treating residents with COVID-19 would be followed. The facility's Infection Preventionist would check the CDC's website on a daily basis for any updates regarding COVID-19. Review of the CDC's COVID-19 guidelines for new admissions titled, Responding To Coronavirus (COVID-19) in Nursing Homes, dated 2019, revealed if the resident must leave his/her room, they must reinforce adherence to universal source control policies and social distancing such as have the resident wear a cloth face covering or face mask and remain at least six (6) feet away from others when outside their room. The guidelines state new residents should be monitored for evidence of COVID-19 for fourteen (14) days after admission and cared for using all recommended COVID-19 personal protective equipment (PPE). Observation of Resident #1 on 06/03/2020 at 9:15 AM, revealed the resident was observed on the ambulance stretcher being transferred from the facility's COVID-19 care unit to the [MEDICAL TREATMENT] clinic. The ambulance crew parked the stretcher with Resident #1 at the Rosewood Place nursing station to talk to the nursing staff. Resident #1 was not observed to have on a face mask. Prior to the ambulance service leaving from the nurses' station Registered Nurse (RN) #1 was observed to place a face mask on the resident. Review of Resident #1's medical record revealed the facility admitted the resident on 05/29/2020, with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessments had not yet been completed. Review of Resident #1's baseline care plan dated 05/29/2020, revealed care plan interventions had been developed for infection related to COVID-19, for contact/droplet precautions for fourteen (14) days. Review of the baseline care plan revealed the care plan developed interventions that required staff to wear PPE (mask, gloves, and gown); however, the care plan did not address the resident coming out of his/her room. Review of physician's orders [REDACTED]. Interview conducted with Registered Nurse (RN) #1 on 06/03/2020 at 9:25 AM, revealed all residents coming out of their rooms on the COVID-19 Unit were required to don a face mask prior to leaving their room. The RN stated any resident going out of the facility was required to wear a face mask. RN #1 stated Resident #1 should have been wearing a face mask before he/she left his/her room. Interview with State Registered Nursing Assistant (SRNA) #1 on 06/03/2020 at 9:33 AM, revealed she assisted SRNA #2 with transferring Resident #1 from his/her bed over to the ambulance stretcher. The SRNA stated the resident had asked them to wait a minute prior to placing the mask on the resident. The SRNA stated she then went to assist another resident. The SRNA stated she should have either waited and placed the mask on Resident #1 or reported it to the nurse. The SRNA stated she had been trained to ensure a mask was placed on residents prior to them leaving the facility. Interview conducted with SRNA #2 on 06/03/2020 at 10:04 AM, revealed she had attempted to place a face mask on Resident #1 and the resident had asked her to wait. The SRNA stated she was required to notify the nurse and should have notified the nurse that the resident did not want to wear the face mask. The SRNA stated she then went with SRNA #1 to assist another resident. Interview conducted with the Infection Preventionist on 06/03/2020 at 10:30 AM, revealed residents on the COVID-19 Unit are encouraged to stay in their room and to don a face mask when out of their room. The Infection Preventionist stated all residents going to out of the facility for appointments or [MEDICAL TREATMENT] were required to don a face mask prior to coming out of their room. The Infection Preventionist stated she monitored daily to ensure staff and residents were donning appropriate PPE and had not identified any concerns. The Infection Preventionist stated Resident #1 should have been wearing a face mask prior to leaving his/her room. Interview conducted with the Director of Nursing (DON) on 06/03/2020 at 11:25 AM, revealed any resident coming out of their room on the COVID-19 Unit was required to don/wear a face mask. If a resident refused to wear a face mask, the SRNA was required to immediately notify the nurse. The DON stated Resident #1 should not have been taken out of his/her room without wearing a face mask. The DON stated the facility utilized CDC guidelines for isolation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE