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

PRINTED: 06/09/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	(X3) DATE SURVEY COMPLETED	
185230		185230	B. WING		ne	06/04/2020	
NAME OF PROVIDER OR SUPPLIER LANDMARK OF ELKHORN CITY REHABILITATION AND NURSIN				STREET ADDRESS, CITY, STATE, ZI 945 WEST RUSSELL STREET ELKHORN CITY, KY 41522			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 000	conducted on 06/04// to be in compliance of Control and has impled Medicare & Medicaid Centers for Disease (CDC) recommended	d infection control survey was 2020. The facility was found with 42 CFR 483.80 Infection emented the Centers for I Services (CMS) and Control and Prevention d practices to prepare for ient practice was identified.	F	000			
			×				
LABORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATU	JRE	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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
185230		B. WING			06/04/2020		
NAME OF PROVIDER OR SUPPLIER LANDMARK OF ELKHORN CITY REHABILITATION AND NURSIN			STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET ELKHORN CITY, KY 41522				
(X4) 1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTION	
E 000	A COVID-19 focused survey was conducte facility was found to the CFR 483.73 Emerger	I Emergency Preparedness d on 06/04/2020. The period in compliance with 42 may Preparedness related to practice was identified.	E	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.

Office of I	nspector General							
STATEMENT OF DEFICIENCIES (X1) PROVIDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
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	_	100521	B. WNG		06/0	4/2020		
NAME OF PE	ROVIDER OR SUPPLIER		RESS, CITY, STA		9 2			
LANDMAR	LANDMARK OF ELKHORN CITY REHABILITATION AN 945 WEST RUSSELL STREET ELKHORN CITY, KY 41522							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
N 000	Initial Comments		N 000					
:	conducted on 06/04/2	infection control survey was 2020. The facility was found oursuant to 42 CFR 483.80. was identified.			37			
	•				80			
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l								

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

TITLE

(X6) DATE