DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/06/2020 FORM APPROVED OMB NO. 0938-0391

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185230	B. WING			C 7/23/2020
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		,, 10, 1020
1011112 01 11				946 WEST RUSSELL STREET		
LANDMAR	RK OF ELKHORN CITY F	REHABILITATION AND NURSIN	Ì	ELKHORN CITY, KY 41522		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	PRECTION	(X5)
PREFIX TAG	(Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETION DATE
F 000	INITIAL COMMENTS	6	F 00	О		
F 656 SS=G	a COVID-19 focused initiated on 07/20/20 07/23/2020. The corand deficient practice highest scope and sefacility was found to CFR 483.80 Infection implemented the Ce Medicaid Services (CD isease Control and recommended practic COVID-19. The total COVID-19. The total complemented the cemplemented they are investigate, they four beside his/her bed we observed touching the Resident #1's bed we position (approximate was transferred to a was diagnosed with and left forehead are the right side (ribs #Pelvic fractures, Celland C2), and fracture Frontal Sinus (facial revealed they had be residents' beds were after care was provincesidents' safety in the residents' safety	mplaint was substantiated e was identified with the everity at "G" level. The be in compliance with 42 n Control and has nters for Medicare & CMS) and Centers for l Prevention (CDC) ices to prepare for al census was 88. pproximately 5:00 AM, staff and when they went to nd Resident #1 on the floor with the resident's head he nightstand. Staff stated has observed in an elevated tely thigh level). Resident #1 local hospital where he/she Hematomas to his/her right heas, Multiple Rib Fractures on 3 - #8), Right Hip and Right roical Spine Fractures (C1 he of his/her Right Outer Table hone). Interviews with staff heen trained to ensure he placed at the lowest position he facility. Comprehensive Care Plan	F 6:	56		
	§483.21(b) Compre §483.21(b)(1) The fi	hensive Care Plans acility must develop and				
LABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATU	RE	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 sateguards 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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185230	B. WING	B. MNG		C 07/23/2020	
	ROVIDER OR SUPPLIER	REHABILITATION AND NURSIN		94	REET ADDRESS, CITY, STATE, ZIP CODE 5 WEST RUSSELL STREET LKHORN CITY, KY 41522	, ,	12012020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	care plan for each resident rights set for §483.10(c)(3), that is objectives and times medical, nursing, ar needs that are ident assessment. The condescribe the following of the physical, mental, ar required under §483.10, includer §483.24, §48 provided due to the under §483.10, includer §483.10, in	ehensive person-centered esident, consistent with the orth at §483.10(c)(2) and includes measurable frames to meet a resident's not mental and psychosocial tified in the comprehensive comprehensive care plan must ng - t are to be furnished to attain dent's highest practicable nd psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required (3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative(s)-goals for admission and preference and potential for acilities must document on the sessed and any referrals to cies and/or other appropriate	F	656			
	(C) Discharge plan plan, as appropriate	, s in the comprehensive care e, in accordance with the orth in paragraph (c) of this					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
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	ROVIDER OR SUPPLIER	REHABILITATION AND NURSIN		STREET ADDRESS, CITY, STATE, ZIP COI 946 WEST RUSSELL STREET ELKHORN CITY, KY 41522		
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F 656	Continued From page	e 2	F€	556	ş	
	by: Based on interview, of the facility policy, if failed to implement at to ensure services waccidents for one (1) residents (Resident record revealed he/s two (2) staff member mobility. Resident # encourage him/her to lowest position when provided. Interviews trained to review resprovide care as directore. However, inte Resident #1 during to revealed the resident reviewed and care he staff member. Resident experienced 06/01/2020. The resident hospital after the diagnosed with Multinght side (Ribs 3-8), and left forehead are Pelvic fractures, Cei	with staff revealed they were ident care plans and to cted in each resident's plan of rview with staff that cared for he night shift on 06/01/2020 it's care plan was not ad been provided by one (1) dent #1's bed was also in the lowest position, and a fall from the bed on sident was transferred to the ne fall where he/she was iple Rib Fractures on his/her. Hematomas to his/her right eas, Right Hip and Right vical Spine Fractures (C1 te of his/her Right Outer Table bone).				

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F 656	Plan Assessment/Conot dated, revealed a Care Plan would be days of completion of MDS Assessment. Tresident's care plan risks, goals, and interisks, goals, and interisks, goals, and interincluded measureab to meet the resident' physical functioning. Interview with the Di 07/23/2020 at 2:15 in policy related to the Aide (SRNA) care plane stated SRNA care information obto Comprehensive Cardirected to provide of care. Review of Resident resident was admitted 05/15/2020 with diagrams.	policy titled, "Baseline Care imprehensive Care Plans," a resident's Comprehensive finalized within seven (7) of the full Comprehensive. The policy also stated the would expand on identified eventions using the plan of care approach which le objectives and timetables is medical, nursing, and needs. The policy also stated the would expand on identified eventions using the plan of care approach which le objectives and timetables is medical, nursing, and needs. The policy titled, "Baseline Care approach which le objective approach which le objective and timetables is medical, nursing, and needs. The policy titled, "Baseline Care approach which le objective approach which le objective and timetables are approach which le objective and timetables are also utilized in the plan of the plan o	F	656			
	Unaware of Safety I admission Minimum dated 05/20/2020 re extensive assistance transfers, bed mobil assessed Resident and bladder and the Mental Status (BIMS	Needs. Resident #1's Data Set Assessment (MDS) Evealed he/she required a of two (2) staff members for ity, and toileting. Staff #1 to be incontinent of bowel a resident's Brief Interview for S) score was 00, which as not interviewable and					

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F 656	Review of Resident is SRNA care plan, "Be 05/15/2020, revealed staff members to proto assist with bed more revealed Resident # staff were to encourabed in the lowest postering provided. Review of Resident is 06/01/2020 at 5:00 A loud bang and found beside his/her bed, it report also indicated touching his/her nighwas elevated. Residuaceration and hemata hematoma to his/her.	#1's comprehensive and edside Kardex Report," dated in he/she required two (2) vide incontinence care and obility. The care plan also 1 was at risk for falls and age the resident to leave the sition when care was not #1's incident report dated AM revealed staff heard a 1 the resident in the floor in a right lateral position. The Resident #1's head was instand and the bed height dent #1 also had a small atoma to the left eyebrow and revealed Resident #1 was I hospital for further	F	356			
	the resident arrived 06/01/2020, at apprevaluated in the Emfall. Further review diagnostic tests were was diagnosed with his/her right side (Right/her right and left and Right Pelvic franctures (C1 and CRight/Outer Table Fillerview with State (SRNA) #3 on 07/2/2	#1's hospital record revealed at a local hospital on eximately 6:59 AM to be ergency Room (ER) after a of the record revealed after e completed, Resident #1 Multiple Rib Fractures on bs 3-8), Hematomas to forehead areas, Right Hip ctures, Cervical Spine (22), and fracture of his/her rontal Sinus (facial bone). Registered Nurse Aide 1/2020 at 11:50 AM and SRNA ta:50 PM revealed at					

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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	approximately 5:00 A at the nurses' station The SRNAs entered observed the resider right side and his/he nightstand. The SRI height was not in the the SRNAs stated it SRNAs, staff had be care plans and to preach resident's plan #3 also stated staff it residents' bed levels after care was provid accidents in the facilitation of 07/22/2020 at 4:0 assigned to care for when the resident explant the care was provided assigned to care for when the resident explant the care was provided to both sides after the care was provided to the facility should be the facility should be the facility should be the facility. LPN #1 also stated ensure bed levels for kept at the lowest let to assist in the previous facility. LPN #1 also during each shift to followed and beds we required.	AM on 06/01/2020, they were and heard a loud noise. Resident #1's room and at lying on the floor on his/her r head was touching a NAs stated Resident #1's bed a lowest position; however, should have been. Per the en trained to review resident poide care as directed in of care. SRNA #2 and SRNA and been trained to ensure were kept at the lowest level ded to assist in preventing	F	656			
	revealed she was a	ssigned to care for Resident then the fall occurred. SRNA					

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		185230	B. WING _		- 1	C /23/2020	
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F 656	#1 stated that ever to review resident to how to care for fac review Resident #1 SRNA #1 also state member that provide the fall occurred, a resident's care plant assistance of two (mobility/incontinenthad repositioned the incontinence care shift prior to the restated she had been beds were kept in was provided, and resident's bed in the she was in the resunsure why Reside height position whe from the bed on 06 Interview with MD at 10:15 AM reveal intervention that sill #1 to keep his/her because that was added to care plant Coordinator stated ensure the beds for were kept at the losafety of the reside #1 required the as members as outling staff were expected.	a though she had been trained care plans for information on illity residents, she had failed to it's care plan as required. Ed she was the only staff ded care to the resident before and was not aware that the inindicated he/she required the 2) staff members for bed dec care. Per the SRNA, she had resident and provided for Resident #1 earlier in the sident's fall. SRNA #1 also en trained to ensure residents' the lowest position after care stated she had placed the he lowest position the last time ident's room. SRNA #1 was ent #1's bed was in an elevated en he/she experienced a fall included the last the lowest position after care affi were to encourage Resident bed at the lowest position a standard intervention she as in the facility. The MDS all staff had been trained to or all residents in the facility west level in height, for the ents. She also stated Resident sistance of two (2) staff led in his/her care plan and do to implement resident care	F	556			
	Interview with the	vas provided in the facility. DON on 07/23/2020 at 2:15 PM been trained to review and				8.5	

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F 689 SS=G	provided to residents also stated staff had resident beds were leposition after care we prevention of accided investigated Resider 06/01/2020 and determine why. The have ensured Resider followed related to the provide assistance as been in the lowest pubeing provided. The Resident #1's bed he position as required, resident sustained for prevented. Free of Accident Hat CFR(s): 483.25(d)(1) The reas free of accident he §483.25(d)(2)Each resident had sustained for prevented.	clans before care was in the facility. The DON been trained to ensure eft in the lowest height as provided, to assist in the ints in the facility. The DON int #1's fall that occurred on ermined his/her bed was left on during the shift on r, she was unable to DON stated staff should ent #1's care plan was ne number of staff required to and his/her bed should have osition when care was not be DON also acknowledged if ad been in the lowest height the amount of injuries the form the fall could have been cards/Supervision/Devices (2)	39	689		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		185230	B. WNG			07/	23/2020
	ROVIDER OR SUPPLIER RK OF ELKHORN CITY F	REHABILITATION AND NURSIN	····	94	TREET ADDRESS, CITY, STATE, ZIP CODE 45 WEST RUSSELL STREET LKHORN CITY, KY 41522		
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F 689	Continued From pag	e 8	F	689			
	by: Based on interview, the facility policy it w failed to ensure each supervision and assi accidents for one (1) residents (Resident approximately 5:00 A and when they went Resident #1 on the fithe resident's head onightstand. Staff states observed in an elevating level). Resider local hospital where Hematomas to his/hareas, Multiple Rib F (ribs #3 - #8), Right fractures, Cervical S and fracture of his/h Sinus (facial bone), they had been trained were placed at the leprovided, to assist in the facility. The findings include Review of the facility Incident Guidelines, facility policy did not heights in ensuring was provided in the interview with the D 07/23/2020 at 2:15 trained to ensure re	record review, and review of as determined the facility in resident received adequate stive devices to prevent of three (3) sampled (41). On 06/01/2020, at AM, staff heard a loud noise to investigate, they found door beside his/her bed with observed touching the ated Resident #1's bed was ated position (approximately int #1 was transferred to a he/she was diagnosed with er right and left forehead fractures on the right side. Hip and Right Pelvic spine Fractures (C1 and C2), er Right Outer Table Frontal Interviews with staff revealed and to ensure residents' beds owest position after care was in ensuring residents' safety in ensuring residents' safety in Policy titled, "Accident and address residents' bed residents' safety after care facility. However, an irector of Nursing on PM revealed all staff had been sident beds were left in the reare was provided to assist					

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		185230	B. WING		07/23/2020
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F 689	9 Continued From page 9		F 689		
	in ensuring the resident	dents' safety and to aid in s in the facility.			
	facility admitted the diagnoses that inclu	#1's record revealed the resident on 05/15/2020 with ded Dementia with Behavioral laware of Safety Needs.			
	Assessment (MDS) Resident #1 require (2) staff members for transfers. The resident incontinent of bowe Interview for Mental which indicated the impaired and not in	dmission Minimum Data Set dated 05/20/2020 revealed dextensive assistance of two or bed mobility, toileting, and dent was assessed to be 1 and bladder and his/her Brief I Status (BIMS) score was 00, resident was cognitively terviewable. The assessment esident had not experienced in the facility.)(1	
	Plan dated 05/20/2: that he/she was at Confusion, Lack of Unsteady on his/he Needs. The care p implemented staff t light was within rearesident to leave hi	t#1's Comprehensive Care 020 revealed staff determined risk for falls related to Coordination, Weakness, or feet, and Unaware of Safety lan also indicated staff o ensure the resident's call ch and to encourage the s/her bed in the lowest position being rendered on			
	5:00 AM revealed s	ent report dated 06/01/2020 at staff heard a loud bang and			
	bed, in a right later indicated the reside nightstand and the	on the floor beside his/her al position. The report also ent's head was touching his/her bed height was elevated. small laceration and			

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	OVIDER OR SUPPLIER	REHABILITATION AND NURSIN		STRE	EET ADDRESS, CITY, STATE, ZIP CODE WEST RUSSELL STREET CHORN CITY, KY 41522	1 071	23/2020
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	to his/her right foreheindicated the facility is bed was in an elevate occurred. Review of Resident # Resident #1 was evalued Emergency Room (Eapproximately 6:59 A fall. The record also tests were completed diagnosed with Hem left forehead areas, I his/her right side (Rit Pelvic fractures, Cerand C2), and fracture Frontal Sinus (facial Interview with State (SRNA) #3 on 07/21. #2 on 07/22/2020 at approximately 5:00 A at the nurses' station The SRNAs stated throom and observed his/her right side and touching his/her night stated the resident's position but not in the SRNAs stated the relevated to thigh levil approximately five (5 head of bed was rais forty-five (45) degree stated they had been beds were in the low	eyebrow and a hematoma ead. The incident report also dentified that Resident #1's ed position when the fall #1's hospital record revealed aluated in a local hospital (R) on 06/01/2020, at (M) after he/she sustained a revealed after diagnostic d, Resident #1 was atomas to his/her right and Multiple Rib Fractures on the position of the first hospital Rib Fractures (C1 er of his/her Right Outer Table	F	689	3.		

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(XS) COMPLETION DATE	
F 689	Interview with Licens on 07/22/2020 at 4:0 assigned to care for occurred on 06/01/20 Resident #1 after the observed the resider side, and raised area sides of the resident bed was in the lower entered his/her room resident's bed was in the fall occurred, untinvestigation conduct the facility. LPN #1 to ensure residents' position after care we ensuring residents' saccidents in the facility accidents in the resident' (30) minutes earlier lowest position. A post exit interview Aide (SRNA) #1 on revealed she was as #1 when the fall occurred stated she had provapproximately 3:00 time) on 06/01/2020 #1's bed in the lower the resident's room.	sed Practical Nurse (LPN) #1 O PM revealed she was Resident #1 when the fall O20. LPN #1 assessed If fall occurred and she It on the floor, on his/her right as were observed to both Is forehead. Resident #1's Is position when the LPN It, and she was not aware the It an elevated position when It of 06/02/2020 during the It deby Administrative staff at Istated staff had been trained Ibeds were in the lowest It as provided to assist in Istafety and preventing Ity. LPN #1 stated she had Its room approximately thirty Istand his/her bed was in the With State Registered Nurse O7/27/2020 at 10:40 AM Issigned to care for Resident Intered on 06/01/2020. She It ided care to the resident at It is and had placed Resident It is position before she exited SRNA #1 also stated she Itember that provided care to	F	689			
	revealed staff had b	ON on 07/23/2020 at 2:15 PM seen trained to ensure e left in the lowest height was provided, to assist in					

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F 689	ensuring accidents were accidents were accidents with the DON conducted #1's fall and determine elevated position dur however, she was un Resident #1's bed was position as required, acknowledged if Resident he lowest height position accident #1's bed was acknowledged if Resident #1's bed was acknowledged #1	an investigation of Resident an investigation of Resident and his/her bed was left in an ing the shift on 06/01/2020; able to determine why as not left in the lowest However, the DON ident #1's bed had been in sition as required, the amount ant sustained from the fall	F	689			

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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	0172012020
(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 CORREC ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
E 000	A COVID-19 focused survey was initiated of concluded on 07/23/2 to be in compliance with the control of the compliance with the compliance of the compliance with the compliance of the complian	2020. The facility was found with 42 CFR 483.73 dness related to E0024. No	EO	000	
				=	
		OKUIDDI IED DEDDESENTATIVE'S SIGNATUE		TITLE	(XS) 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.

Event ID: P2S011

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
- 17	a		A. Bollebino.			c			
100521			B. WING			/23/2020			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
LANDMARK OF ELKHORN CITY REHABILITATION AN 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)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
N 000	COVID-19 focused in initiated on 07/20/20/ 07/23/2020. The cor and deficient practice 42 CFR 483.10-483.	ation (KY32023) and a infection control survey was 20 and concluded on inplaint was substantiated a was identified pursuant to 95. No deficient practice if to the infection control		N 000					
				M	::- :::-				

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

TITLE

(X6) DATE