STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185230	A. BUILDING _____ B. WING _____	C 07/23/2020

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LANDMARK OF ELKHORN CITY REHABILITATION AND NURSIN	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)	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 An abbreviated standard survey (KY32023) and a COVID-19 focused infection control survey was initiated on 07/20/2020 and concluded on 07/23/2020. The complaint was substantiated and deficient practice was identified with the highest scope and severity at "G" level. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The total census was 88. On 06/01/2020, at approximately 5:00 AM, staff heard a loud noise and when they went to investigate, they found Resident #1 on the floor beside his/her bed with the resident's head observed touching the nightstand. Staff stated Resident #1's bed was observed in an elevated position (approximately thigh level). Resident #1 was transferred to a local hospital where he/she was diagnosed with Hematomas to his/her right and left forehead areas, Multiple Rib Fractures on the right side (ribs #3 - #8), Right Hip and Right Pelvic fractures, Cervical Spine Fractures (C1 and C2), and fracture of his/her Right Outer Table Frontal Sinus (facial bone). Interviews with staff revealed they had been trained to ensure residents' beds were placed at the lowest position after care was provided, to assist in ensuring residents' safety in the facility.	F 000		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		

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.

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F 656	Continued From page 1 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656		

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F 656	Continued From page 2	F 656		

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and a review of the facility policy, it was determined the facility failed to implement a person-centered care plan to ensure services were furnished to prevent accidents for one (1) of three (3) sampled residents (Resident #1). Review of Resident #1's record revealed he/she required assistance of two (2) staff members with toileting and bed mobility. Resident #1's care plan directed staff to encourage him/her to leave his/her bed in the lowest position when care was not being provided. Interviews with staff revealed they were trained to review resident care plans and to provide care as directed in each resident's plan of care. However, interview with staff that cared for Resident #1 during the night shift on 06/01/2020 revealed the resident's care plan was not reviewed and care had been provided by one (1) staff member. Resident #1's bed was also observed not to be in the lowest position, and he/she experienced a fall from the bed on 06/01/2020. The resident was transferred to the local hospital after the fall where he/she was diagnosed with Multiple Rib Fractures on his/her right side (Ribs 3-8), Hematomas to his/her right and left forehead areas, Right Hip and Right Pelvic fractures, Cervical Spine Fractures (C1 and C2), and fracture of his/her Right Outer Table Frontal Sinus (facial bone).

The findings include:

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F 656	Continued From page 3 Review of the facility policy titled, "Baseline Care Plan Assessment/Comprehensive Care Plans," not dated, revealed a resident's Comprehensive Care Plan would be finalized within seven (7) days of completion of the full Comprehensive MDS Assessment. The policy also stated the resident's care plan would expand on identified risks, goals, and interventions using the "Person-Centered" plan of care approach which included measureable objectives and timetables to meet the resident's medical, nursing, and physical functioning needs. Interview with the Director of Nursing on 07/23/2020 at 2:15 PM revealed the facility had no policy related to the State Registered Nurse Aide (SRNA) care plans in the facility; however, she stated SRNA care plans were developed from information obtained from the Comprehensive Care Plan, and staff were directed to provide care as outlined in the plan of care. Review of Resident #1's record revealed the resident was admitted to the facility on 05/15/2020 with diagnoses that included Dementia with Behavioral Disturbances and Unaware of Safety Needs. Resident #1's admission Minimum Data Set Assessment (MDS) dated 05/20/2020 revealed he/she required extensive assistance of two (2) staff members for transfers, bed mobility, and toileting. Staff assessed Resident #1 to be incontinent of bowel and bladder and the resident's Brief Interview for Mental Status (BIMS) score was 00, which indicated he/she was not interviewable and cognitively impaired.	F 656		

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Review of Resident #1's comprehensive and SRNA care plan, "Bedside Kardex Report," dated 05/15/2020, revealed he/she required two (2) staff members to provide incontinence care and to assist with bed mobility. The care plan also revealed Resident #1 was at risk for falls and staff were to encourage the resident to leave the bed in the lowest position when care was not being provided.

Review of Resident #1's incident report dated 06/01/2020 at 5:00 AM revealed staff heard a loud bang and found the resident in the floor beside his/her bed, in a right lateral position. The report also indicated Resident #1's head was touching his/her nightstand and the bed height was elevated. Resident #1 also had a small laceration and hematoma to the left eyebrow and a hematoma to his/her right forehead. Continued review of the report revealed Resident #1 was transferred to a local hospital for further evaluation and treatment.

Review of Resident #1's hospital record revealed the resident arrived at a local hospital on 06/01/2020, at approximately 6:59 AM to be evaluated in the Emergency Room (ER) after a fall. Further review of the record revealed after diagnostic tests were completed, Resident #1 was diagnosed with Multiple Rib Fractures on his/her right side (Ribs 3-8), Hematomas to his/her right and left forehead areas, Right Hip and Right Pelvic fractures, Cervical Spine Fractures (C1 and C2), and fracture of his/her Right Outer Table Frontal Sinus (facial bone).

Interview with State Registered Nurse Aide (SRNA) #3 on 07/21/2020 at 11:50 AM and SRNA #2 on 07/22/2020 at 4:50 PM revealed at

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approximately 5:00 AM on 06/01/2020, they were at the nurses' station and heard a loud noise. The SRNAs entered Resident #1's room and observed the resident lying on the floor on his/her right side and his/her head was touching a nightstand. The SRNAs stated Resident #1's bed height was not in the lowest position; however, the SRNAs stated it should have been. Per the SRNAs, staff had been trained to review resident care plans and to provide care as directed in each resident's plan of care. SRNA #2 and SRNA #3 also stated staff had been trained to ensure residents' bed levels were kept at the lowest level after care was provided to assist in preventing accidents in the facility.

Interview with Licensed Practical Nurse (LPN) #1 on 07/22/2020 at 4:00 PM revealed she was assigned to care for Resident #1 on 06/01/2020, when the resident experienced a fall in the facility. LPN #1 stated Resident #1 was observed on the floor, on his/her right side, and raised areas were observed to both sides of his/her forehead. LPN #1 stated staff had been trained to review each resident's plan of care and that care provided in the facility should be directed from the care plans. The LPN also stated staff had been trained to ensure bed levels for residents in the facility were kept at the lowest level after care was provided, to assist in the prevention of accidents in the facility. LPN #1 also stated nurses made rounds during each shift to ensure care plans were followed and beds were in the lowest position as required.

A post exit interview with State Registered Nurse Aide (SRNA) #1 on 07/27/2020 at 10:40 AM revealed she was assigned to care for Resident #1 on 06/01/2020 when the fall occurred. SRNA

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F 656	Continued From page 6 #1 stated that even though she had been trained to review resident care plans for information on how to care for facility residents, she had failed to review Resident #1's care plan as required. SRNA #1 also stated she was the only staff member that provided care to the resident before the fall occurred, and was not aware that the resident's care plan indicated he/she required the assistance of two (2) staff members for bed mobility/incontinence care. Per the SRNA, she had repositioned the resident and provided incontinence care for Resident #1 earlier in the shift prior to the resident's fall. SRNA #1 also stated she had been trained to ensure residents' beds were kept in the lowest position after care was provided, and stated she had placed the resident's bed in the lowest position the last time she was in the resident's room. SRNA #1 was unsure why Resident #1's bed was in an elevated height position when he/she experienced a fall from the bed on 06/01/2020. Interview with MDS Coordinator #1 on 07/23/2020 at 10:15 AM revealed she had included the intervention that staff were to encourage Resident #1 to keep his/her bed at the lowest position because that was a standard intervention she added to care plans in the facility. The MDS Coordinator stated all staff had been trained to ensure the beds for all residents in the facility were kept at the lowest level in height, for the safety of the residents. She also stated Resident #1 required the assistance of two (2) staff members as outlined in his/her care plan and staff were expected to implement resident care plans when care was provided in the facility. Interview with the DON on 07/23/2020 at 2:15 PM revealed staff had been trained to review and	F 656		

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F 656	Continued From page 7 follow resident care plans before care was provided to residents in the facility. The DON also stated staff had been trained to ensure resident beds were left in the lowest height position after care was provided, to assist in the prevention of accidents in the facility. The DON investigated Resident #1's fall that occurred on 06/01/2020 and determined his/her bed was left in an elevated position during the shift on 06/01/2020; however, she was unable to determine why. The DON stated staff should have ensured Resident #1's care plan was followed related to the number of staff required to provide assistance and his/her bed should have been in the lowest position when care was not being provided. The DON also acknowledged if Resident #1's bed had been in the lowest height position as required, the amount of injuries the resident sustained from the fall could have been prevented.	F 656		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		

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F 689	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility policy it was determined the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for one (1) of three (3) sampled residents (Resident #1). On 06/01/2020, at approximately 5:00 AM, staff heard a loud noise and when they went to investigate, they found Resident #1 on the floor beside his/her bed with the resident's head observed touching the nightstand. Staff stated Resident #1's bed was observed in an elevated position (approximately thigh level). Resident #1 was transferred to a local hospital where he/she was diagnosed with Hematomas to his/her right and left forehead areas, Multiple Rib Fractures on the right side (ribs #3 - #8), Right Hip and Right Pelvic fractures, Cervical Spine Fractures (C1 and C2), and fracture of his/her Right Outer Table Frontal Sinus (facial bone). Interviews with staff revealed they had been trained to ensure residents' beds were placed at the lowest position after care was provided, to assist in ensuring residents' safety in the facility. The findings include: Review of the facility policy titled, "Accident and Incident Guidelines," not dated, revealed the facility policy did not address residents' bed heights in ensuring residents' safety after care was provided in the facility. However, an interview with the Director of Nursing on 07/23/2020 at 2:15 PM revealed all staff had been trained to ensure resident beds were left in the lowest position after care was provided to assist	F 689		

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in ensuring the residents' safety and to aid in preventing accidents in the facility.

Review of Resident #1's record revealed the facility admitted the resident on 05/15/2020 with diagnoses that included Dementia with Behavioral Disturbances and Unaware of Safety Needs.

Review of his/her admission Minimum Data Set Assessment (MDS) dated 05/20/2020 revealed Resident #1 required extensive assistance of two (2) staff members for bed mobility, toileting, and transfers. The resident was assessed to be incontinent of bowel and bladder and his/her Brief Interview for Mental Status (BIMS) score was 00, which indicated the resident was cognitively impaired and not interviewable. The assessment also revealed the resident had not experienced any previous falls in the facility.

Review of Resident #1's Comprehensive Care Plan dated 05/20/2020 revealed staff determined that he/she was at risk for falls related to Confusion, Lack of Coordination, Weakness, Unsteady on his/her feet, and Unaware of Safety Needs. The care plan also indicated staff implemented staff to ensure the resident's call light was within reach and to encourage the resident to leave his/her bed in the lowest position when care was not being rendered on 05/27/2020.

Review of an incident report dated 06/01/2020 at 5:00 AM revealed staff heard a loud bang and found Resident #1 on the floor beside his/her bed, in a right lateral position. The report also indicated the resident's head was touching his/her nightstand and the bed height was elevated. Resident #1 had a small laceration and

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hematoma to the left eyebrow and a hematoma to his/her right forehead. The incident report also indicated the facility identified that Resident #1's bed was in an elevated position when the fall occurred.

Review of Resident #1's hospital record revealed Resident #1 was evaluated in a local hospital Emergency Room (ER) on 06/01/2020, at approximately 6:59 AM after he/she sustained a fall. The record also revealed after diagnostic tests were completed, Resident #1 was diagnosed with Hematomas to his/her right and left forehead areas, Multiple Rib Fractures on his/her right side (Ribs 3-8), Right Hip and Right Pelvic fractures, Cervical Spine Fractures (C1 and C2), and fracture of his/her Right Outer Table Frontal Sinus (facial bone).

Interview with State Registered Nurse Aide (SRNA) #3 on 07/21/2020 at 11:50 AM and SRNA #2 on 07/22/2020 at 4:50 PM revealed at approximately 5:00 AM on 06/01/2020, they were at the nurses' station and heard a loud noise. The SRNAs stated they entered Resident #1's room and observed him/her lying on the floor on his/her right side and the resident's head was touching his/her nightstand. The SRNAs also stated the resident's bed was "not in the highest position but not in the lowest position either." The SRNAs stated the resident's bed height was elevated to thigh level (SRNA #3 stated she was approximately five (5) feet tall), and the resident's head of bed was raised to approximately a forty-five (45) degree angle. Both staff members stated they had been trained to ensure residents' beds were in the lowest position after providing care to assist in preventing accidents in the facility.

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F 689	Continued From page 11 Interview with Licensed Practical Nurse (LPN) #1 on 07/22/2020 at 4:00 PM revealed she was assigned to care for Resident #1 when the fall occurred on 06/01/2020. LPN #1 assessed Resident #1 after the fall occurred and she observed the resident on the floor, on his/her right side, and raised areas were observed to both sides of the resident's forehead. Resident #1's bed was in the lowest position when the LPN entered his/her room, and she was not aware the resident's bed was in an elevated position when the fall occurred, until 06/02/2020 during the investigation conducted by Administrative staff at the facility. LPN #1 stated staff had been trained to ensure residents' beds were in the lowest position after care was provided to assist in ensuring residents' safety and preventing accidents in the facility. LPN #1 stated she had been in the resident's room approximately thirty (30) minutes earlier and his/her bed was in the lowest position. A post exit interview with State Registered Nurse Aide (SRNA) #1 on 07/27/2020 at 10:40 AM revealed she was assigned to care for Resident #1 when the fall occurred on 06/01/2020. She stated she had provided care to the resident at approximately 3:00 AM (unable to recall exact time) on 06/01/2020 and had placed Resident #1's bed in the lowest position before she exited the resident's room. SRNA #1 also stated she was the only staff member that provided care to the resident before the fall occurred. Interview with the DON on 07/23/2020 at 2:15 PM revealed staff had been trained to ensure residents' beds were left in the lowest height position after care was provided, to assist in	F 689		

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F 689	Continued From page 12 ensuring accidents were prevented in the facility. The DON conducted an investigation of Resident #1's fall and determined his/her bed was left in an elevated position during the shift on 06/01/2020; however, she was unable to determine why Resident #1's bed was not left in the lowest position as required. However, the DON acknowledged if Resident #1's bed had been in the lowest height position as required, the amount of injuries the resident sustained from the fall could have been prevented.	F 689		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185230	A. BUILDING _____ B. WING _____	C 07/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF ELKHORN CITY REHABILITATION AND NURSIN	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 focused Emergency Preparedness survey was initiated on 07/20/2020 and concluded on 07/23/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E0024. No deficient 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 Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100521	A. BUILDING: _____ B. WING _____	C 07/23/2020

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) 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) COMPLETE DATE
N 000	Initial Comments A complaint investigation (KY32023) and a COVID-19 focused infection control survey was initiated on 07/20/2020 and concluded on 07/23/2020. The complaint was substantiated and deficient practice was identified pursuant to 42 CFR 483.10-483.95. No deficient practice was identified related to the infection control survey.	N 000		

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