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

PRINTED: 07/17/2020 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 SURVEY COMPLETED		
25		185065	B. WNG		C 07/14/2020		
	ROVIDER OR SUPPLIER	HABILITATION AND NURSING C	STREET ADDRESS, CITY, STATE, ZIP CODE  308 WEST MAPLE AVENUE  LANCASTER, KY 40444				
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 000	a COVID-19 focused initiated on 07/13/20	ndard survey (KY31961) and d infection control survey was 020 and concluded on	F 00	00			
(1)	and no deficient pra facility was found to CFR 483.80 Infection implemented the Ce	enters for Medicare & CMS) and Centers for d Prevention (CDC) tices to prepare for					
		27					
:		9					
			8		Sa .		
LABORATORY	! 'DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATU	RE A	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.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/17/2020 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICARD SERVICES			I	<del></del>	T 140. 0330-0331
STATEMENT OF DEFICIENCIES (X1) PRO AND PLAN OF CORRECTION IDEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		185065	B. WNG		С
		185065			07/14/2020
NAME OF PROVIDER OR SUPPLIER  LANDMARK OF LANCASTER REHABILITATION AND NURSING C			30	REET ADDRESS, CITY, STATE, ZIP CODE 8 WEST MAPLE AVENUE ANCASTER, KY 40444	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLÉTION
E 000	Initial Comments	**	E 000	# · · · ·	) *E
55	survey was initiated of concluded on 07/14/2 to be in compliance w	2020. The facility was found with 42 CFR 483.73 Iness related to E0024. No		₹	
5	X A			±9	25
33 W		•0,	-	W	
ARODATORY	DIDECTOR'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 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING: \_ С B. WNG\_ 100719 07/14/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **308 WEST MAPLE AVENUE** LANDMARK OF LANCASTER REHABILITATION AND I LANCASTER, KY 40444 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 000 N 000 Initial Comments A complaint investigation (KY31961) and a COVID-19 focused infection control survey was initiated on 07/13/2020 and concluded on 07/14/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X8) DATE