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) MULT		(X3) DATE SURVEY COMPLETED		
			A. BUILDING			С	
		185293	B. WING	B. WING		07/14/2020	
NAME OF PROVIDER OR SUPPLIER LANDMARK OF LAUREL CREEK REHABILITATION AND NURSIN				10	REET ADDRESS, CITY, STATE, ZIP CODE 33 NORTH HIGHWAY 11 ANCHESTER, KY 40962		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)			(X5) COMPLETION DATE
F 000	An abbreviated stan a COVID-19 focused initiated on 07/13/20 07/14/2020. The cor and no deficient pract facility was found to CFR 483.80 Infection implemented the Ce	dard survey (KY31959) and infection control survey was 20 and concluded on applaint was unsubstantiated circe was identified. The be in compliance with 42 in Control and has inters for Medicare & CMS) and Centers for Prevention (CDC) ices to prepare for	F	000			
		R/SUPPI IER REPRESENTATIVE'S SIGNATU			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		(1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
					· · ·	С	
		185293	B. WING_	B. WING		07/14/2020	
NAME OF PR	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
				10	33 NORTH HIGHWAY 11		- 1
LANDMARK OF LAUREL CREEK REHABILITATION AND NURSIN				M	ANCHESTER, KY 40962		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		E	(X5) COMPLETION DATE
E 000	Initial Comments		E	E 000			
	A COVID-19 focused Emergency Preparedness survey was initiated on 07/13/2020 and concluded on 07/14/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E0024. No						;
-2	deficient practice wa						
						:	
	!						
	14.						
:							
LABORATORY	/ DIDECTOR'S OR PROMPE	R/SUPPLIER REPRESENTATIVE'S SIGNATURI			TITLE		(X6) DATE

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Facility ID 100502

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ C B. WING 07/14/2020 100502 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1033 NORTH HIGHWAY 11 LANDMARK OF LAUREL CREEK REHABILITATION A! MANCHESTER, KY 40962 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 000 N 000 Initial Comments A complaint investigation (KY31959) 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

(XS) DATE