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

PRINTED: 01/12/2021 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	
	185230		B. WING		12/30/2020		
NAME OF PROVIDER OR SUPPLIER LANDMARK OF ELKHORN CITY REHABILITATION AND NURSI				STREET ADDRESS, CITY, STA 945 WEST RUSSELL STRE ELKHORN CITY, KY 415	ET		
(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 (EACH CORRECTIVE ACTION SHOWN TAG CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)		E ACTION SHOULD TO THE APPROP	D BE COMPLETION	
F 000	A COVID-19 focus conducted on 12/3 to be in compliance Control and has im Medicare & Medica Centers for Diseas (CDC) recomment COVID-19. No detail The total census w	sed infection control survey was 0/2020. The facility was found a with 42 CFR 483.80 Infection plemented the Centers for aid Services (CMS) and a Control and Prevention led practices to prepare for ficient practice was identified.		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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185230		185230	B. WING			12/30/2020	
	PROVIDER OR SUPPLIER	ITY REHABILITATION AND NURS	IN	94	REET ADDRESS, CITY, STATE, ZIP CODE 5 WEST RUSSELL STREET LKHORN CITY, KY 41522		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SH		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	survey was conduct facility was found to CFR 483.73 Emer	sed Emergency Preparedness cted on 12/30/2020. The o be in compliance with 42 gency Preparedness related to nt practice was identified.	E	000			
						**	5
LABORATO	RY DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SK	GNATURE		TITLE		(X6) DATE

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Facility ID: 100521

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING 100521 12/30/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET LANDMARK OF ELKHORN CITY REHABILITAT **ELKHORN CITY, KY 41522** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 000 **Initial Comments** N 000 A COVID-19 focused infection control survey was conducted on 12/30/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.

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

TITLE

(X6) DATE