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

PRINTED: 11/30/2020 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	
		185293	B. WING		11	11/09/2020	
NAME OF PROVIDER OR SUPPLIER LANDMARK OF LAUREL CREEK REHABILITATION AND NURSIN				STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, 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 CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP		OULD BE	(X5) COMPLETION DATE	
F 000	A COVID-19 focused conducted on 11/09/3 to be in compliance v Control and has implemented to be in compliance of the control o	d infection control survey was 2020. The facility was found with 42 CFR 483.80 Infection emented the Centers for I Services (CMS) and Control and Prevention d practices to prepare for ient practice was identified.			PROPRIATE	DATE	
	A DISTANCE OF SECURE	oku iddi ied deddesentatives signati ide		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 CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/30/2020 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	
		185293	B, WING		11	11/09/2020	
NAME OF PROVIDER OR SUPPLIER LANDMARK OF LAUREL CREEK REHABILITATION AND NURSIN				STREET ADDRESS, CITY, STATE, ZIP COL 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962	DE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
E 000	survey was conducte was found to be in co 483.73 Emergency F	d Emergency Preparedness and on 11/09/2020. The facility compliance with 42 CFR dreparedness related to practice was identified.	E	000			
		OCUIDBUGD DEDDESSMIATIVE'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.

PRINTED: 11/30/2020 FORM APPROVED

Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WNG_ 100502 11/09/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 LANDMARK OF LAUREL CREEK REHABILITATION AF MANCHESTER, KY 40962 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETÉ DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was conducted on 11/09/2020. 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

9P2D11