

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Danville Centre for Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 642 North Third Street Danville, KY 40422	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview, record review, and review of the facility's policy, the facility failed to ensure residents were allowed to return to the facility for 1 of 5 sampled residents (Resident (R)1). The findings include: Review of the facility's policy titled, Clinical Discharge and Transfer: Transfer/Discharge Notice, revised 02/03/2025, revealed the facility was committed to ensuring all transfers and discharges were conducted in a manner that respected the rights, dignity, and welfare of residents while complying with federal and state regulations. Continued review of the policy revealed it established procedures to ensure appropriate notice, documentation, and support for safe and orderly transitions. Per review of the facility policy, the facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. Further policy review revealed if the facility determined a resident, who was transferred with an expectation of returning to the facility, could not return to the facility, the facility must comply with the (federal regulatory) requirements of 483.15 (c) as they applied to discharges. Review of the facility's policy titled, Clinical Discharge and Transfer: Facility Bed-Hold, revised 02/03/2025, revealed if a resident with a bed-hold was transferred with the expectation of returning to the facility at the time of transfer, and ultimately could not return, the facility was to comply with any applicable discharge rules. Review of the Face sheet for R1 revealed the facility admitted the resident on 08/06/2021, with diagnoses of schizoaffective disorder, dementia, and cognitive communication deficit. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/19/2026, revealed the facility assessed R1 as having a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated moderate cognitive impairment. Review of R1's Care Plan, dated 05/06/2026, revealed the facility identified a problem for the resident as at risk and/or active behaviors such as physically abusive and verbally abusive towards staff related to delusional beliefs that were difficult to redirect. Continued review of the Care Plan revealed the interventions included every 15 minute checks of R1, and to reapproach resident later when he became less agitated. Review of the Progress Note, dated 07/06/2026 at 2:51 PM, written by Licensed Practical Nurse (LPN) 1, revealed R1 had stated, I'm getting out of here one way or another. Continued review of the Progress Note revealed R1 had picked up a chair and started hitting the door and grabbed the wrists of Unit Manager (UM) 1. Further review revealed staff attempted redirection and R1 was given a soft drink and went to his room on the memory care unit. Review of the Progress Note, dated 07/06/2026 at 2:53 PM, written by the UM 1, revealed R1 had been banging on the door to get it open with a chair and when UM 1 came to assist with redirection, the resident grabbed her wrists and squeezed them and was not redirectable. Continued review of the Progress Note revealed staff offered R1 a soda and he went and sat down to watch television. Additionally review revealed, about 30 minutes later, UM 1 was called back to the unit and it was reported R1 had went back to his room to use the bathroom. (continued on next page)		

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.

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

TITLE

(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review revealed staff reported hearing a loud noise and when they went to investigate it, they found R1 holding a wheelchair leg rest and a shattered window. (Review of the Progress Note for R1, dated 07/06/2026 at 2:53 PM, written by Unit Manager (UM) 1, revealed the resident had been found in his room holding a wheelchair leg rest after taking it to the window causing it to shatter. Continued review of the Note revealed 9-1-1 was notified and the hospital was called to give report that R1 was being transferred to them. Per review of the Note, UM 1 had sent over the transfer policy and bed hold policy to the hospital via fax. Review of the Progress Note, dated 07/06/2026 at 3:25 PM, written by Licensed Practical Nurse (LPN) 2, revealed Emergency Medical Services had been at the facility and had transported R1 to the hospital. Review of the facility document titled, Witness Statement, dated 07/06/2026, written by the Administrator, revealed the Administrator spoke with the emergency room (ER) Physician regarding R1's behavior. Continued review of the facility document revealed the Administrator informed the Physician that R1 had displayed behaviors at the facility, which put other residents and staff in danger. Additionally, review revealed the Administrator told the ER Physician R1 had busted out a six-inch window from the memory care unit. However, per review of the witness statement, the ER Physician told the Administrator there was no medical or psychiatric reason for R1 to be admitted to the hospital. Review of the facility's untitled document, dated 07/10/2026, revealed the facility ethics committee held a meeting to discuss discharging R1 from the facility on 07/06/2026. Review of the hospital ER General Exam Note, dated 07/06/2026, written by the ER Physician, revealed the Physician consulted psychiatry services who evaluated R1. Per review of the Note, psychiatry services deemed there was no psychiatric benefit for hospital admission and R1 should return to the facility. Review of the Hospital Behavioral Health Services (BHS) Intake Assessment documentation, dated 07/06/2026 at 4:37 PM, written by the BHS intake nurse, revealed R1 had told her he got upset that his sitter did not show up and so he broke a window at the facility. Continued review of the Intake Assessment documentation revealed R1 had been alert and oriented times four (oriented to person, place, time, and situation). Per review, R1 had been logical with no hallucinations or delusions, and had good judgement. Additionally, review revealed R1 denied wanting to hurt himself or others. Further review of the Intake Assessment revealed R1 had not met criteria for (hospital) admission and was to be referred back to the facility. Review of the Hospital Progress Note, dated 07/06/2026 at 6:55 PM, written by Registered Nurse (RN) 3, revealed she had spoken with the facility's Administrator regarding R1's return to the facility. Review revealed however, RN 3 had been told R1 could not return to the facility. Review of the Hospital Progress Note, dated 07/06/2026 at 7:30 PM, written by RN 4, revealed R1 had been cleared and had no medical or psychiatric qualifiers for (hospital) admission. Continued review of the Progress Note revealed the Administrator of the facility denied abandoning R1. Further review of the Note revealed RN 4 noted however, the facility did not have a room for R1, as the broken window was to be fixed the next day. Review of the Hospital Progress Note, dated 07/07/2026 at 7:49 AM, written by RN 1, revealed facility staff told the hospital staff the window would be fixed by 12:00 PM that day. Review of the Hospital Progress Note, dated 07/07/2026 at 2:04 PM, written by the Hospital Case Manager (CM), revealed the facility community liaison came to the hospital and saw R1 and was told by hospital staff, and was told the resident would not be admitted to the hospital. Continued review of the Note revealed facility staff were told by the Hospital CM R1 could not stay at the hospital long term and had been discharged for about 22 hours with zero aggression noted and was directable. Review of the Hospital Progress Note, dated 07/07/2026 at 2:07 PM, written by the hospital ER Unit Facilitator, revealed the facility's administration was refusing to take R1 back at the facility. Further review of the Note revealed the facility's administration told the Facilitator R1 was unsafe to return to the facility. In (continued on next page)		

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