DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		185329	B. WING _			04/09/2020	
NAME OF P	ROVIDER OR SUPPLIER	-		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MODOAN		HABILITATION CENTER		50	9 NORTH CARRIER STREET		
WORGAN	TELD NORSING AND RE			M	ORGANFIELD, KY 42437		
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F 000		d Infection Control Survey	F	000			
	04/09/2020. There wa identified with 42 CFF regulations and the fa Centers for Medicare and Centers for Disea	8/2020 and concluded on as no deficient practice & 483.80 infection control acility has implemented the & Medicaid Services (CMS) ase Control and Prevention practices to prepare for sus 52.					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUI	RE		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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 185329 B. WING 04/09/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH CARRIER STREET MORGANFIELD NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH CARRIER STREET (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION concentration should be (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE com (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH OERECTIVE ACTION SHOULD BE com PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE com TAG REGULATORY OR LSC IDENTIFYING INFORMATION) E 000 E 000 E 000 FREFIX COM A COVID-19 Focused Emergency Preparedness Survey was initiated on 04/08/2020 and concluded on 04/09/2020. There was no deficient practice identified with 42 CFR 483.73 E 000 Image: Common section	CENTERS	S FOR MEDICARE &	MEDICAID SERVICES					
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