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

PRINTED: 05/08/2020 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		
		185316	B. WING		04/17/2020		
NAME OF PROVIDER OR SUPPLIER PRINCETON NURSING & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN STREET PRINCETON, KY 42445			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
F 000	INITIAL COMMENTS An Abbreviated Survey investigating #KY31536 and a COVID-19 Focused Infection Control Survey was initiated on 04/13/2020 and concluded on 04/17/2020. There was no deficient practice identified at the 42 CFR 483.80 infection control regulations and the facility had implemented the Centers of Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19. Total census 73. KY31536 was substantiated with deficiencies cited at the highest Scope and Severity of a "D". The State Survey Agency validated the facility had identified and corrected the deficient practice on 04/12/2020, prior to the State Survey Agency entering the building on 04/13/20. Therefore, the State Survey Agency determined the facility had past non-compliance.		TAG CROSS-REFERENCED TO THE APPR				
ADODATORY		SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE		

(X6) DATE

05/08/2020

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.

Facility ID: 100049

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NAME OF PROVIDER OR SUPPLIER PRINCETON NURSING & REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER PRINCETON NURSING & REHABILITATION (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments A COVID-19 Emergency Preparedness Survey was initiated on 04/13/2020 and concluded on 04/17/2020. The facility was found to be in compliance with 42 CFR 483.73 related to			185316	B. WING		04	04/17/2020	
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compliance with 42 CFR 483.73 related to	E 000	A COVID-19 Emergency Preparedness Survey		E	000			
		compliance with 42 C						
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DA							(X6) DATE	

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Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _		(3) DATE SURVEY COMPLETED				
	100049	B. WING		04/17/20)20			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
PRINCETON NURSING & REHABILITATION 1333 WEST MAIN STREET PRINCETON, KY 42445								
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE C	(X5) OMPLETE DATE			
N 000 Initial Comments		N 000						
A Complaint Survey (#	fection Control Survey was and concluded on s no deficient practice 2 CFR 483.80.	N 000						

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

TITLE

(X6) DATE 05/08/20

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