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

PRINTED: 06/10/2020 FORM APPROVED OMB NO. 0938-0391

MADISONVILLE HEALTH AND REHABILITATION, LLC CAMPID C	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 MADISONVILLE HEALTH AND REHABILITATION, LLC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 05/18/2020 and concluded on 05/19/2020. There was no deficient practice identified with 42 CFR 483.80 infection control regulations and the facility has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for			185015	B. WING			05/19/2020	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 05/18/2020 and concluded on 05/19/2020. There was no deficient practice identified with 42 CFR 483.80 infection control regulations and the facility has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for				•	419 NORTH SEMINARY ST	CODE		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		A COVID-19 Focuse was initiated on 05/18 05/19/2020. There waidentified with 42 CFF regulations and the facenters for Medicare and Centers for Disea (CDC) recommended COVID-19. Total cens	d Infection Control Survey 8/2020 and concluded on as no deficient practice R 483.80 infection control acility has implemented the & Medicaid Services (CMS) ase Control and Prevention d practices to prepare for sus 81					

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185015	B. WING			05/19/2020	
NAME OF PROVIDER OR SUPPLIER MADISONVILLE HEALTH AND REHABILITATION, LLC				STREET ADDRESS, CITY, STATE, ZIP 419 NORTH SEMINARY ST MADISONVILLE, KY 42431	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
E 000	Survey was initiated of concluded on 05/19/2	d Emergency Preparedness on 05/18/2020 and 2020. There was no deficient th 42 CFR 483.73 related to	E				
I ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	EF	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.

Facility ID: 100185

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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: _	(X3) DATE SURVEY COMPLETED		
	100185	B. WING		05/19/2020	
NAME OF PROVIDER OR SUPPLIER MADISONVILLE HEALTH AND REHABILITATION, LLC MADISONVILLE, KY 42431					
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEI	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
N 000 Initial Comments A COVID-19 Focused Infect was initiated 05/18/2020 an 05/19/2020. There was no identified pursuant to 42 CF	nd concluded on deficient practice	N 000			

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

TITLE (X6) DATE