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

PRINTED: 06/09/2020 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 | | |
|---|--|---|--|---|-------------------------------|-------|--|
| | 185263 | | B. WING _ | | 05/22/2020 | | |
| NAME OF PROVIDER OR SUPPLIER DAWSON SPRINGS HEALTH AND REHABILITATION CENTER | | | , | STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408 | · | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE COMPLE | ETION | |
| F 000 | A COVID-19 Focuse was initiated on 05/2 05/22/2020. The facil compliance with 42 0 regulations and has i Medicare & Medicaid Centers for Disease | d Infection Control Survey 1/2020 and concluded on ity was found to be in CFR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention If practices to prepare for | FO | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'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.

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| E 000 | Survey was initiated of concluded on 05/22/2 | d Emergency Preparedness on 05/21/2020 and 020. The facility was found with 42 CFR 483.73 related | E | 000 | | | |

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

TITLE (X6) DATE

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Facility ID: 100188

PRINTED: 06/09/2020 FORM APPROVED

Office of Inspector General

| NAME OF PROVIDER OR SUPPLIER DAWSON SPRINGS HEALTH AND REHABILITATION C CA4 ID PREPRIX REGILATORY OR IS CIDENTIFYING INFORMATION TAG N 000 Initial Comments A COVID-19 Focused Infection Control Survey was initiated 05/21/2020 and concluded on 05/22/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | | | DATE SURVEY COMPLETED | | |
|--|--|---|------------------|----|---------|---|------------------------------|----------|--|
| DAWSON SPRINGS HEALTH AND REHABILITATION C X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE | 100188 | | | | B. WING | | | 22/2020 | |
| DAWSON SPRINGS HEALTH AND REHABILITATION C DAWSON SPRINGS, KY 42408 (X4) ID PREFIX TAG N 000 Initial Comments A COVID-19 Focused Infection Control Survey was initiated 05/21/2020 and concluded on 05/22/2020. The facility was found to be in | | | | | | | | | |
| PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 000 Initial Comments A COVID-19 Focused Infection Control Survey was initiated 05/21/2020 and concluded on 05/22/2020. The facility was found to be in | DAWSON | SPRINGS HEALTH AND | REHABILITATION C | | | | | | |
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| was initiated 05/21/2020 and concluded on 05/22/2020. The facility was found to be in | N 000 | Initial Comments | | | N 000 | | | | |
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